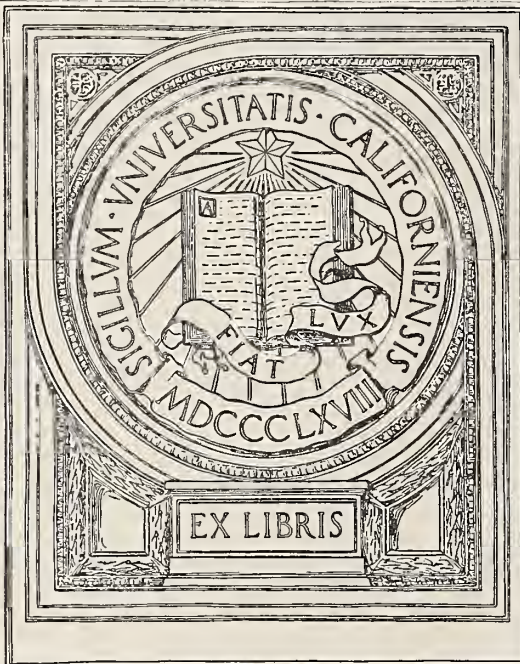


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THE TREATMENT OF SEVERE AND MALIGNANT HYPERTENSION

Louis L. Battey, M.D., J. Edwin Wood, M.D. and
Julian Williams, M.D., *Augusta*

- ***Accelerated hypertension requires early recognition and prompt lowering of pressure if irreparable renal damage is to be avoided***

THE SYNDROME OF MALIGNANT hypertension is characterized by a high diastolic pressure, an accelerated course and rapidly progressive renal damage. It is usually preceded by primary (essential) or secondary hypertension. Retinal hemorrhages, exudates and papilledema of the optic discs characterize the syndrome. Papilledema is the cardinal sign in establishing the diagnosis of malignant hypertension.¹ The natural course of malignant hypertension is that of rapid progression to uremia unless terminated along the way by complicating brain or heart damage. In a recent series of 105 untreated patients mortality was 90 per cent at the end of one year.² The average survival without treatment is nine months after the occurrence of papilledema. Spontaneous remissions have been reported but are extremely rare.

The frequency of this malignant or accelerated phase of hypertension is reported to be about seven per cent in a group of hypertensive patients.³ The syndrome of essential hypertension is estimated to occur in approximately ten per cent of the American population.

It is the purpose of this article to define the nature of severe, advanced hypertension as a public health problem in the State of Georgia and to give our experience with its therapy with particular reference to the use of the drug, guanethidine.

State Mortality Statistics

Mortality statistics in the past decade from the Department of Public Health of the State of Georgia relative to the problem of hypertension have been summarized in Table I. This table shows all of

TABLE I

Total*	1950	1953	1956	1960
Age	2,785	2,619	2,222	2,066
20-29	18	16	6	9
30-39	108	82	76	49
40-49	259	227	195	183
50-59	490	492	403	343
60-69	716	635	541	494

Total Deaths (All Causes) . 30,416 30,754 31,582 35,324

*Deaths in Georgia From Causes Related to Hypertension (1951-1960)
International Classification Code Numbers 441-446.

the deaths in Georgia listed as being related to hypertension. These are given for various age groups during the last ten years and were obtained from the following diagnostic classifications:

- (1) Essential Malignant Hypertensive Heart Disease.
- (2) Hypertensive Heart Disease with Arteriolar Nephrosclerosis.
- (3) Unspecified Hypertensive Heart Disease.
- (4) Essential Benign Hypertension.
- (5) Essential Malignant Hypertension.

TREATMENT OF HYPERTENSION Continued

Although the accuracy of the individual figures in these mortality statistics might be subject to question, the general downward trend in mortality is clearly shown. This significant decrease in death rate of approximately 37 per cent is perhaps a result of the increasing effectiveness of hypotensive agents.

The percentage of these deaths that were actually due to malignant hypertension cannot be accurately stated, as they lose their identity under the five separate diagnoses. However, one would expect that

the deaths due to hypertension in the age group of 30 to 49 years would include a high incidence of malignant hypertension as other studies have suggested. The death rate due to hypertension in this age group has also decreased by approximately 46 per cent during the past ten years, Table I. One might speculate that the decrease in mortality in this younger age group is partially due to the prevention of the fatal outcome in the malignant syndrome. An additional interesting possibility is that there has been actual reduction in the incidence of malignant hypertension due to more effective hypotensive drug therapy. Further studies are needed to

TABLE II
Deaths Due to Malignant Hypertension
E.T.M.H.—1956-1960

Pt.	Age	Sex	Race	Admission BUN(mgm %)	Cause of Death	Autopsy Diagnosis
RH	56	M	W	150 NPN	Uremia	nephrosclerosis
WH	41	F	C	222	Uremia	nephrosclerosis pulmonary edema
RWM	42	F	C	213	Uremia	nephrosclerosis and retained products of conception
LMB	28	F	C	129	Uremia	nephrosclerosis
MA	48	M	C	150	Uremia	nephrosclerosis, acute pyelonephritis, fibrinoid necrosis
LMM	40	F	C	207 NPN	Uremia	nephrosclerosis, chronic pyelonephritis
JWC	36	M	C	209 NPN	Uremia	nephrosclerosis, fibrinoid necrosis, pyelonephritis left kidney
CC	45	M	C	125	Uremia	nephrosclerosis, fibrinoid necrosis
CW	35	M	C	248	Uremia	chronic glomerulo-nephritis, malignant nephrosclerosis, moderate
LW	65	F	C	116 NPN	Uremia	nephrosclerosis, atrophy of right kidney with multiple cysts
EH	57	M	C	178 NPN	Uremia	nephrosclerosis, fibrinoid necrosis
JTJ	20	M	C	120	Uremia	nephrosclerosis
WD	47	M	C	168	Uremia	nephrosclerosis, fibrinoid necrosis, lobar pneumonia
ETY	16	M	W	96	Uremia	chronic glomerulonephritis, nephrosclerosis, fibrinoid necrosis
FM	37	F	C	216	Uremia	nephrosclerosis, fibrinoid necrosis
EWT	54	M	C	147	Uremia	nephrosclerosis
EH	45	M	W	86	post-operative exploratory laboratory for G.I. bleeding	nephrosclerosis, fibrinoid necrosis, multiple acute stomach ulcers
LMS	44	F	C	175	Uremia	nephrosclerosis
JLW	40	M	W	150	Uremia	nephrosclerosis, congenital defect of right renal artery, pulmonary edema and ulcer in the intestine
SL	36	F	C	117	Uremia	None
LMD	52	F	C	155	Uremia	None
LB	28	M	C	36—8 mos prior to death	Uremia	renal biopsy, chronic pyelonephritis, chronic lipoid nephrosis, nephrosclerosis
IJ	37	F	C	153	renal failure following dialysis. Electrolyte imbalance while on digitalis following dialysis—possible digitalis intoxication	renal biopsy, nephrosclerosis

TABLE III
Patients Who Died Following Discharge From Hospital

Pt.	Age	Sex	Race	Admission BUN(mgm %)	Cause of Death	Autopsy Diagnosis
HW	40	M	C	108	CHF and Uremia	None
AB	48	M	C	48	Cerebral Hemorrhage	None
FS	24	M	W	43	Uremia	None
TCH	30	M	W	82 NPN	Unknown cause	None
SJ	30	F	C	66 NPN	Unknown cause	None
WC	45	M	C	72	CHF	None
WMG	25	M	C	27	Uremia	None
ZMP	28	F	C	63	Uremia	None

investigate the effect of drug therapy on the actual incidence of this syndrome.

Malignant hypertension requires early recognition and prompt effective lowering of pressure before renal damage passes "the point of no return." Numerous studies have shown that the effectiveness of hypotensive drug therapy is inversely proportional to the degree of renal damage present. A complete reversal of the malignant syndrome and a five year survival rate of approximately 50 per cent can be expected if treatment is begun before renal function is reduced by one half.⁴ Tables II and III show the more important features of an unselected series of 31 deaths due to malignant hypertension in the past four years at Talmadge Memorial Hospital. Ages ranged from 16 to 65 with an average of 40 years. Six patients were white and 25 were Negro, showing a marked racial predominance which does not exist in the general hospital population (approximate ratio 40 per cent Negro to 60 per cent white). Males appear more susceptible to malignant hypertension than females in contrast to the higher incidence of essential hypertension in females.

A marked elevation of BUN was present on hospital admission in all of the cases. The range of BUN was 36 to 248 mgm per cent in the patients who died during hospitalization (Table II). This advanced degree of renal damage made effective hypotensive therapy impossible. Hypotensive therapy made the uremia worse presumably by lowering the effective glomerular filtration. In all of these cases (Tables II and III) death resulted from uremia in 25 out of the 29 cases in which the cause of death was determined. One patient died of congestive failure and one of cerebral hemorrhage.

In brief, the underlying renal pathology was compatible with pre-existing essential hypertension in 15 out of 21 cases. There were two cases of chronic glomerulonephritis, two of chronic pyelonephritis and two of unilateral renal disease.

The patients in Table III were dismissed from the

hospital and died later. In general the level of BUN on admission was lower (range 27 to 108 mgm per cent) in this group than in those described above. Hypotensive therapy during hospitalization did not appear to intensify the uremia. At the time of dismissal a satisfactory hypotension had been produced with ganglionic blocking agents or with guanethidine alone or in combination with hydrochlorothiazide. No information is available as to their medication at time of death as they were not seen after dismissal.

In the past decade this clinic has been oriented toward the outpatient diagnosis and treatment of young patients with severe diastolic hypertension. A number of drugs have been used including rauwolfia compounds, hydralazine, the gaglionic blocking agents and more recently the thiazide drugs and guanethidine.¹ Our experience with ganglionic blocking agents was comparable to that reported by others. Such drugs as pentolinium, mecamlamine and trimethidinium were very effective in lowering blood pressure if the dose was carefully titrated. They were useful in the control of severe and malignant hypertension. However, with ganglionic blocking agents there is a constantly shifting level of blood pressure, an excessive tendency to postural hypotension, and unpleasant side effects due to parasympathetic blockade.

Mechanism of Action

The ganglionic blocking agents prevent the passage of impulses through the autonomic ganglia by a competitive antagonism with acetylcholine at that site. This results in signs of both sympathetic and parasympathetic blockade. Reserpine acts mainly by depletion of norepinephrine from both the central and peripheral portions of the sympathetic outflow. Guanethidine acts on the peripheral terminals of the sympathetic nerves and decreased tissue stores of norepinephrine. Vascular response after guanethidine to sympathetic nerve stimulus is markedly dim-

TREATMENT OF HYPERTENSION
Continued

inished. Hypotensive responses are accompanied by orthostatic hypotension and diminution in cardiac output. The latter is thought to hinge upon peripheral venous pooling with loss of venomotor responses due to reduced sympathetic nerve activity.⁵

Chlorothiazide drugs are believed to act primarily by sodium depletion of the arteriolar smooth muscle cell itself, resulting in a diminished vascular reactivity to sympathetic nerve impulses and to circulating pressor agents such as norepinephrine and perhaps angiotensin.

Results — Individual Cases

An example of long-term therapy of malignant hypertension is shown in Figure I. The patient's

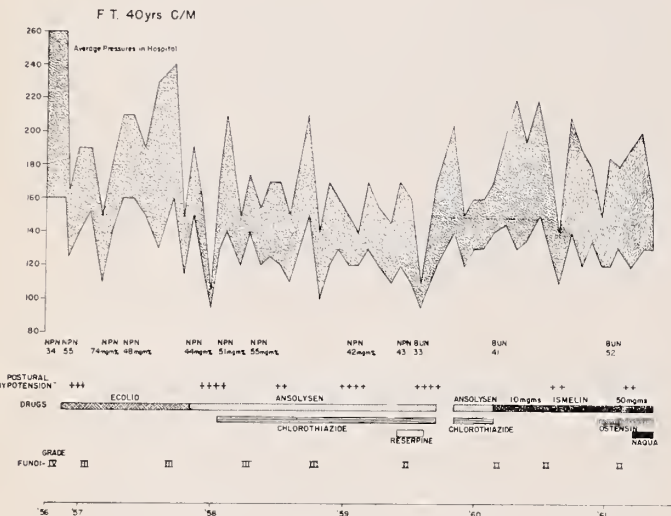


Figure I

retinopathy regressed from Grade IV to Grade II on a variety of hypotensive agents. His blood pressure has never been completely controlled because of excessive hypotension. Despite this, he has been carried for over four years with borderline renal function. At the present time he is taking a combination consisting of trimethidinium, guanethidine and trichlor-methiazide. There is evidence of a slow progression of renal damage. However, he is comfortable and has far outlived the expected eight months average survival of eyeground changes in a patient with malignant hypertension is seen in Figure 2. The

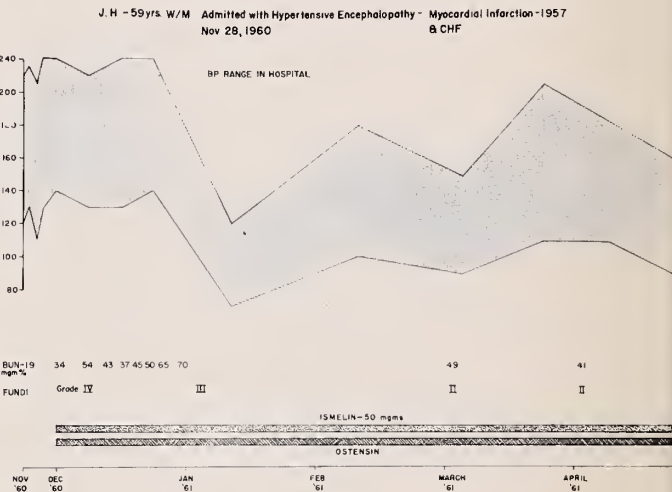


Figure 2

deterioration in renal function was halted. Renal function improved but still remains abnormal.

Table IV shows the results in eight patients with malignant hypertension undertreatment using guanethidine alone and in combination with other drugs.

TABLE IV
Results of Therapy of Malignant Hypertension on Outpatient Basis

Pt.	age	Race	Sex	B. P. Range		Grade of Fundi		BUN		Duration Rx. (mos.)	Drugs
				Before	After	Before	After	Before	After		
KLB	56	C	F	260/140	150/100	III	II	38	25	14	Ismelin
GOR	51	C	M	220/140	190/100	III	II	9	18	5	Ismelin
FT	41	C	M	260/160	160/120	IV	II	33	52	53	Ecolid—1956 Ansoiyen—1957 Ostensin—1960 Ismelin—1960-61 Chlorothiazide—1961
JH	59	W	M	220/120	160/90	IV	II	70	41	17	Ismelin
ECW	49	C	F	260/132	180/100	III	II	21	28	12 7	Ismelin Ostensin
BD	52	C	F	180/120	160/100	IV	II		19	13 7	Ismelin + Ostensin
AD	54	C	M	320/180	140/100	IV	III	54	43	6 4	Ismelin + Ostensin
JW	56	C	M	300/160	180/110	III	II	20	32	16 6	Ismelin + Ostensin Chlorothiazide

The average duration of treatment is 14 months. Four patients (not shown) died in uremia. Two of these died when they omitted their drug for periods of two weeks, and three weeks respectively.

Table V shows a group of 40 patients with an

TABLE V
Results of Therapy of Severe Hypertension

Diastolic Range (sitting)	Ismelin	Ismelin- Thiazide	Ismelin- Ostensin	TOTALS
Below 100 mm. Hg.	18	5	4	27 (68%)
100-110 mm. Hg.	3	2	2	7 (17%)
Above 110 m.m Hg.	2	1	3	6 (15%)

Forty patients treated.
Ages range 29 to 63 years. Average 48 years.
Duration of therapy 5 to 18 months. Average 12 months.
Diastolic pressure before therapy 110-180 mm. Hg. Average 130 m.m Hg.

average age of 48 years and an average pre-treatment diastolic level of 130 mm. Hg. Our arbitrary but practical goal in therapy of this type patient is to achieve a consistent diastolic pressure below 100 mm. Hg in the sitting position. This goal was attained in approximately 70 per cent of the patients with guanethidine alone or in combination with other drugs. An appreciable reduction of systolic and diastolic pressures occurred in every patient given guanethidine. This hypotensive effect was more marked in the erect position but was present also in the supine position. More recently, we have been impressed with the use of the combination of hydrochlorothiazide and guanethidine. There appears to be a more effective lowering of pressure in the supine position with this combination.

The side effects were comparable to those reported elsewhere. Occasional diarrhea occurred that usually improved with time and reduction of dosage. Lack of ejaculation is troublesome in some patients. One patient had three episodes of priapism within a two-week period that may have been related to the predominance of parasympathetic tone seen with this drug. However, this patient also has the sickle cell trait which may be associated with priapism. There has been no recurrence on continued medication with guanethidine. Extreme brachycardia may be observed if reserpine and guanethidine are given together. The simultaneous use of these drugs is therefore contraindicated. Muscular weakness and fatigue as reported by others⁶ have not been frequent side effects in our experience and have never been severe enough to require discontinuance of the drug.

Postural hypotension appeared to be less troublesome if a hydrochlorothiazide drug was added. The average effective daily dose of guanethidine alone was 40 to 75 mgm when given in single or divided doses. The effective dose of hydrochlorothiazide was 50 mgm. daily.

Summary

(1) The mortality rate in Georgia from severe and malignant hypertensive vascular disease appears to have been favorably altered by the more extensive use of hypotensive drug therapy within the past decade.

(2) Malignant hypertension remains a serious health problem in Georgia. In its advanced stage it is uniformly fatal. At an earlier stage it can be controlled before renal failure occurs.

(3) A more aggressive attack on this problem is needed. This would consist of earlier recognition of the syndrome by thorough fundiscopic examination in every hypertensive patient. Secondary hypertension due to surgically correctable causes should be ruled out as rapidly as possible so that effective hypotensive treatment can be begun before renal damage proceeds too far.

(4) Guanethidine alone or in combination with a thiazide drug in the treatment of severe and malignant hypertension has proved to be a most consistently effective drug in the treatment of severe and malignant hypertension.

Medical College of Georgia

The various drugs used in the past ten years were kindly supplied by the following pharmaceutical companies: Rauwolfia root (Rau-dixin), Squibb Institute for Therapeutic Research; mecamlamine (Inversine), Merck, Sharp and Dohme Research Laboratories; pentolinium (Ansolyen) and trimethidinium (Ostensin), Wyeth Laboratories; hexamethonium (Methium), Warner-Chilcott Laboratories; reserpine (Serpasil), hydrochlorothiazide (Esidrix) and guanethidine (Ismelin), by Ciba Pharmaceutical Products, Inc.

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A CLINICIAN'S VIEW OF ANABOLIC STEROIDS

Roy A. Wiggins, Jr., M.D., *Atlanta*

■ *The concept of a striking dissociation of anabolism and androgenicity in these agents is tenuous*

ALL OF LIFE is a function of the formation of protein. In youth, anabolic activity outweighs catabolic activity and growth occurs. In maturity, essential equality obtains to the end that destroyed tissue is adequately replaced and homeostasis maintained. In senility, some aspects of deterioration are functions of the individual to build tissue at a pace sufficient to maintain the *status quo*. Many factors govern tissue anabolism, *e.g.*, growth hormone, adequate caloric intake, thyroid hormone and the gonadal steroid hormones.

Much has been written recently about anabolic steroids. It is the purpose of this paper to examine these compounds and to bring them into proper perspective. Some disagreement exists as to whether these hormonal effects are actually pro-anabolic or anti-catabolic. For our purposes, the word anabolism suggests the state in which the algebraic sum of constructive tissue activity outweighs destructive activity.

Great emphasis has been placed upon the dissociation of anabolic or tissue building effect and androgen or masculinizing effect of certain synthetic compounds. So great has been this emphasis that the phrase "anabolic steroids" suggests the image of tissue growth without masculinization. This concept is tenuous. It derives most of its support from an animal assay suggested by Gordan and Eisenberg¹. Anabolic effect is reflected by growth of the levator ani muscle and androgenic effect by ventral prostatic growth in suitable laboratory animals. It is doubtful whether growth of the levator ani is divorced from androgen effect. However, we have

treated one pituitary dwarf who complained of priapism and nocturnal emission while taking 100 milligrams of testosterone propionate weekly, but did not have these symptoms on a dose of Dianabol® with 50 per cent more anabolic effect. A double blind study done by Heller² and associates in hypopituitary patients suggests a true difference in androgen effect existing between natural testosterone and synthetic steroids, further supporting the thesis of dissociation of anabolic and androgenic activity.

The tissue-sparing effects of testosterone have been discussed widely. The reader is referred to E. C. Reinfenstein's extensive review for pertinent metabolic studies³. It is apparent that nitrogen is retained after injections of testosterone and that potassium, sulfur and phosphorous excretion are also decreased. If one assumes an "ideal tissue" to contain elements in a ratio of 15 grams nitrogen to three grams potassium to one gram of phosphorus and one gram of sulfur, the retention of potassium, sulfur and phosphorus calculated from retained nitrogen is amazingly near the observed values. If one adjusts the phosphate retention with relation to that deposited with nitrogen in soft tissues, then the phosphorus not obligated to nitrogen may be related to retained calcium. Indeed, the 2/1 ration of calcium to phosphorus found in bone, is reflected in the balance data obtained after administration of testosterone. One infers from this that elements retained may well be deposited in bone and soft tissues.

Such effects are not limited to natural androgens. Liddle and Burke⁴ have shown that many synthetic compounds have qualitative effects resembling

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those of testosterone, but quantitatively different. For example, one milligram of delta 1-2 methyl testosterone (Dianabol®) is nine to ten times as active as one milligram of methyl testosterone and norethandrolone (Nilevar®) is two to three times as effective.

The clinical use of the tissue building steroid compounds has been vigorously described in the drug house literature. One finds a brief bibliography of such uses in publications of Grant Liddle. We would like to address ourselves to consideration of anabolic steroids in surgery, adrenal steroid therapy and in management of patients with renal failure, chronic and acute.

Surgery

Moore⁵ has said that the androgens are effective in most surgical cases because of appetite stimulation. One can frequently create a positive nitrogen balance in the postoperative period with cortisone. Moore ascribes this apparent paradox to appetite stimulation since tissue building proceeds most efficiently with a ratio of nitrogen to calories to body weight of the order of 0.1 to 30 to 1. That is, seven grams nitrogen to 2100 calories for a 70 kilogram person.

It is fallacious reasoning to expect anabolic steroids to give striking benefit to the surgical patient with abscesses and wound infections. Indeed, in animals with turpentine abscesses, one can hardly demonstrate nitrogen retention with administration of androgenic substance.

Excess Glucocorticoid

The clinical picture of muscle wasting seen in Cushing's syndrome and in patients with longstanding cortisone treatment is well known. Riefenstein's review includes interesting short-term and long-term experiments to show the catabolic effect of ACTH and cortisone and its reversal with androgen therapy.

This effect is sufficiently striking to warrant administration of an anabolic agent in all adults subjected to long-term glucocorticoid therapy. Glenn Clark⁶ feels that the use of anabolic steroids in conjunction with glucocorticoid therapy of rheumatoid arthritis has allowed use of a smaller dose of the cortisone-like drugs.

Renal Failure

J. P. Merrill⁷, Arthur Merrill⁸, Blagg and others⁹ have discussed the role of anabolic steroids in renal failure. It would appear that these compounds are effective in delaying the accumulation of the products of tissue breakdown in certain cases. The best results have been obtained in patients who experience acute renal insufficiency due to catastrophe as-

sociated with childbirth. Subjects with an accumulation of nitrogen sufficient to cause a rise in the blood NPN of 30 mg per cent per day or less, regardless of the etiology of the renal failure benefit from addition of anabolic steroids to the treatment regimen. In instances where massive tissue destruction has occurred or wide infection exists, the anabolic steroids seem to be ineffective, certainly less effective.

Patients with chronic renal failure who are otherwise in a plateau state will frequently show a fall in blood non-protein nitrogen with androgen therapy. It must be emphasized that these compounds will influence the course most strikingly when the other factors are at a state of equilibrium. Superimposed pneumonia, for example, will easily override the observed improvement attending androgen therapy.

An ameliorative effect is most likely due to tissue sparing effected by the steroid. Blagg has shown that, in selected cases, the tissue sparing effect of anabolic drugs exceeds the maximum effect of hypertonic glucose.

Although the kidneys hypertrophy in animals treated with androgens and certain animals experience an increased renal work capability, the human fails to follow this trend. Lattimer¹⁰ has been unable to demonstrate significant changes in glomerular filtration rate or renal blood flow in human subjects treated with large doses of testosterone.

Complications

The synthetic and natural androgens cause sodium retention. This has been of no consequence in the few balance studies we have done. Preedy¹¹ has shown that the female gonadal steroid (also anabolic) estradiol induces sodium retention most notably in patients with liver disease. Normal subjects and patients with congestive heart failure exhibit sodium retention of degree inconsequential clinically. Salt and water retention must be anticipated in patients taking gonadal steroids.

Masculinization does occur with synthetic anabolic agents, although probably to a lesser degree than with naturally occurring androgens. This effect is relieved by withdrawal of the drug. We have not used these agents in children, fearing induction of epiphyseal closure. This may well be avoided by using small dosages and intermittent brief treatment periods. Liddle⁴ has shown that the maximum protein sparing dosage of Dianabol® is 17 per cent of the dose required to produce acne in females and eight per cent of the daily dose required to replace testicular loss in adult males. Similar data are needed for other anabolic compounds.

Cholestatic jaundice and BSP retention have been the most striking complication of therapy with anabolic steroids. This effect, first reported by Werner,

ANABOLIC STEROIDS / Wiggins

et al.¹², in patients given methyl testosterone, is a reversible phenomenon early in its course. The jaundice which can be seen with most of these drugs probably reflects the effect of anabolic steroids to inhibit formation of glucuronic acid conjugates of bilirubin. The same mechanism is invoked to explain the falls in urinary steroid levels. BSP retention is seen, and again is thought to be only a chemical lesion in its early stages. Discontinuation of treatment is attended by recovery.

Summary

Testosterone and synthetic testosterone-like steroids are capable of effecting nitrogen retention, evidently by favoring protein anabolism. These substances are similar in qualitative effects, but differ in the quantitative aspects of change induced per milligram of drug. While the synthetic compounds are probably less androgenic than natural testosterone, the concept of striking dissociation of anabolism and androgenicity is tenuous.

Postoperative benefit is probably due to appetite stimulation offering the patient proper nutrition. In patients subjected to long-term treatment with cortisone, much of the tissue wasting may be prevented by concomitant anabolic steroid treatment. Acute and subacute renal failure patients probably benefit from administration of androgens—many acute patients requiring less vigorous dialysis and the chroni-

cally ill patients returning toward normal when all other considerations are equal.

The anabolic steroids may induce retention of salt and water, masculinization and chemical lesions reflected by jaundice and BSP retention.

While incapable of awesome effects, anabolic steroids favorably influence the course of illness in selected patients.

35 Fourth Street

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TRIBUTE TO DR. WASDEN

The Thomas-Brooks Medical Society adopted the following resolution after the death of Howell A. Wasden, Jr., M.D. of Pavo, October 16, 1961:

"The death of Howell A. Wasden, Jr., has brought sorrow to a host of people who loved, trusted and admired him and it will be difficult to fill the place he has so ably and efficiently filled in Pavo and Thomas County."

Howell A. Wasden, Jr., was born June 17, 1914 in Midville, Georgia. He received his M.D. degree from the Medical College of Georgia in 1944. His General Practice Training was received at the University Hospital, Augusta, Georgia. He served with the United States Army Medical Corps from 1945 until 1947.

"He was a member of the Thomas-Brooks Medical Society, Medical Association of Georgia, and the American Medical Association."

"As Dr. Wasden has had such an outstanding part in all phases of religious and civic life in his community; and

"As he has labored faithfully and efficiently in alle-

viating suffering humanity regardless of race, color, creed, social or financial conditions; and

As he was beloved and held in esteem by his many patients and friends:

BE IT RESOLVED:

"That Pavo and Thomas County has lost a most valued and efficient physician; and

That the Thomas-Brooks Medical Society has lost a member who was a friend to and co-worker with each member and whose presence will be missed always; and

BE IT FURTHER RESOLVED: that a copy of these resolutions be put in the minutes of the Thomas-Brooks Medical Society, a copy to be sent to the family of Dr. Wasden, and a copy to be sent to the Thomasville Times Enterprise and the Journal of the Medical Association of Georgia."

Signed,

Julian B. Neel, M.D.,

Secretary Thomas-Brooks Medical Society.

TRANSURETHRAL PROSTATECTOMY

Harold P. McDonald, M.D., Wilborn E. Upchurch, M.D.
and Carlos L. Celaya, M.D., *Atlanta*

■ *The present day status of this procedure is discussed*

TWENTY-SEVEN YEARS AGO my late chief Dr. Edgar Ballenger stated "Comparing 25 years of open prostatectomy experience with our results following 240 transurethral resections during the past two years (1931-33) leaves the comparison strongly favoring the transurethral resection method."

This was a part of his address as guest speaker before a medical meeting in New Orleans, given in December, 1933.

It is my purpose today, 27 years and some 4000 transurethral resections later, to speak of the present day status of transurethral resection or preferably transurethral prostatectomy.

Since the time of Caulk, Davis, McCarthy, Ballenger, Folsom, Bumpus, Kretschmer and others, all pioneers in urology and in transurethral surgery, a great many improvements have come to all fields of medicine and surgery. These improvements have had the effect of making common place many surgical procedures not previously possible, and greatly improving the results in many others; so that today almost no patient should be denied needed surgery. It is not necessary nor does time permit the enumeration of the many discoveries and advances in medicine and surgery that have taken place during these past three decades. It suffices to say however, that improvements in anesthesia, blood volume maintenance, control of infections, improvements in instruments and other advances too numerous to mention have been of great benefit not only to urology but to all branches of medicine and surgery.

The fact is that the aforementioned surgical advances have made all types of prostatectomy far less hazardous for the patient than formerly was the case. However, without the improved techniques in

anesthesia, blood replacement by transfusions and newer antibacterial medicines, it is safe to say that open prostatectomy rarely would be performed today. It is a fact that for some urologists the percentage of prostatic patients on whom the transurethral method is employed has dropped from about 90 per cent or more 25 years ago to 50 per cent or less today. There are several factors in this apparent decline in favor of transurethral prostatectomy operations. First it must still be recognized that technically transurethral prostatectomy remains a very difficult operation to perform. The large gland is tedious to remove, and the operative time and wear and tear on the operator is greater than when open prostatectomy is performed. The difficulty of learning and acquiring expertness in transurethral surgery plus the improvements in open surgery actually tend to narrow the width of superiority of transurethral prostatectomy.

In October, 1932 before the Georgia Urological Association, we said, "Concerning the types and sizes of obstructions suitable for the resection method there is little diversity of opinion. The cautious beginner has rightly limited resections to bars and prostatic obstructions of small and medium size. With increasing experience, skill and confidence, more medium size and somewhat larger masses have been successfully attacked. It is agreed by all that the very large glands should be removed by open prostatectomy." This is essentially the position we find ourselves today, almost three decades later.

"How Permanent are the Results of Transurethral Prostatic Resection?" This was the title of a paper given by us before the Medical Association of Georgia in Savannah in 1944. It was pointed out that

TRANSURETHRAL PROSTATECTOMY

Continued

permanent good results from transurethral prostatectomy depend upon complete removal of all obstructing tissue and in most instances this represents 85 per cent to 90 per cent of the total prostate gland. In speaking of the cause for poor results, we stated, "The resectionists who made cystourethroscopic examinations post-operatively of the vesical neck in search of reasons for poor results soon saw why the relief had not been afforded. The inadequate removal of obstructing tissue was quite evident. Then by more complete transurethral resection, lasting freedom in voiding was made possible."

It is still true today that inadequate transurethral resections afford at best only temporary relief from obstruction. A careful, complete transurethral prostatectomy however does afford permanent good results. In a recent study of more than 2000 transurethral prostatectomy operations done by us from 1940 to 1955 those patients who later developed obstruction which required relief numbered 57 or less than three per cent of the total.

Diagnosis

The use of excretory urograms has largely replaced the cystourethroscopic examination in diagnosis of prostatic or vesical neck obstruction. Good preparation and proper radiographic technique can usually reveal the presence of intravesical obstruction which, when correlated with the history of urgency, weak or diminished urinary stream, nocturia frequency or other bladder symptoms, an often painful pre-operative cystoscopy is not needed.

Present day post-operative care for transurethral prostatectomy patients has changed little over the past 25 years, except for infection control. The pres-

ent day transurethral patient is less likely to have an elevation of temperature above normal than his counterpart 25 years ago. More careful attention to sterile operative technique and prophylactic use of antibacterial measures have surely contributed to this improvement. The present day transurethral prostatectomy patient usually has negative urine, free from infection, by the end of six or eight weeks post-operatively. Judicious use of urine cultures, sensitivity tests and antibacterial medicines has contributed greatly to this improvement.

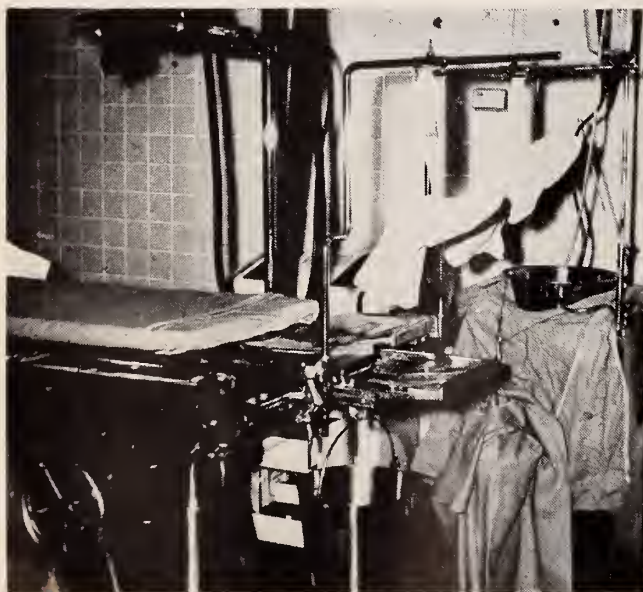
Of interest to us has been the almost total absence of phlebitis and thrombophlebitis post-operatively. This fact we attribute to use of boot stirrups instead of ordinary leg stirrups, commonly found on the usual cystoscopy tables. These boot straps were first advocated by Alcock 25 years ago, and yet are not generally in use today, a fact that is hard for us to understand. (Figure 1)

The present day mortality following transurethral prostatectomy is in the range of one to two per cent. We have had many series of 100 consecutive operations without a mortality.

The length of hospital stay is practically unchanged during the past 25 years, being still from five to seven days post-operatively.

The sexual function after transurethral prostatectomy is usually preserved and at times may be improved. Almost no patient has less potentia than before the operation. It is true that the ejaculation of semen may be entirely within the prostatic fossa and not outward through the urethra. This does not lessen the sensation and after proper explanation very few patients are disturbed by this fact.

Complications are almost eliminated in present day transurethral prostatectomy operations. Post-operative urethral strictures at one time were reported to occur as often as 20 per cent of all cases.



Left: Photograph of table with boot straps on leg holders.



Figure 1
Right: Photograph of patient in place. Note absence of popliteal pressure.

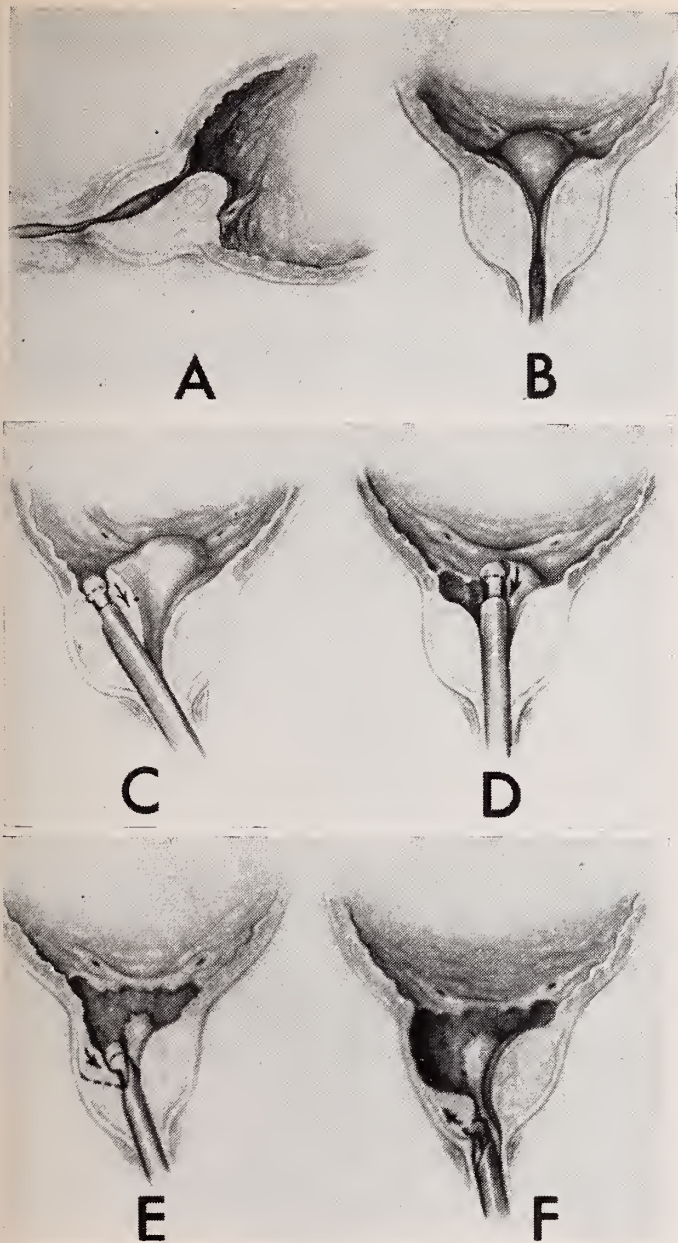


Figure 2

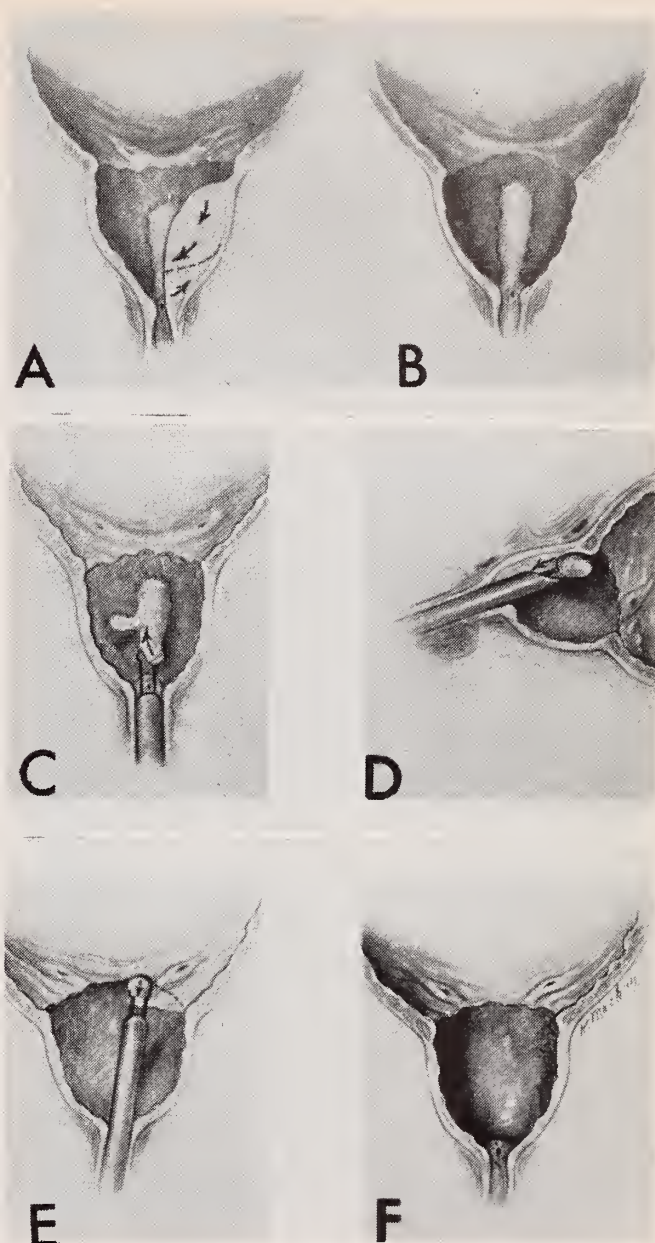


Figure 3

A, Sagittal and B, Coronal sections thru prostatic area showing enlarged lateral and posterior lobes.
C, D, E, F: Steps in transurethral resection of right lateral and middle lobe.

A, B: Continuing steps in removal of tissue from left lateral lobe.
C, D: Removal of middle lobe and tissue from roof of prostatic fossa.
E, F: Trimming edge of fossa at interureteric ridge.



Figure 4

Left: Mass of resected prostatic tissue weighing 60 gms.

Right: Enucleated prostate gland weighing 90 gms.

TRANSURETHRAL PROSTATECTOMY
Continued

Such strictures have virtually been eliminated by pre-operative calibration of the urethra by Otis bougies and correction of narrow or strictured points before the resectoscope is passed.

Intravascular hemolysis, with often attendant oliguria or anuria post-operatively is prevented by the use of glycine, cytal or other non hemolizing solution as irrigating media.

Technique

It is thought that a brief summary of our present day technique should be helpful in assessment of the present day status of transurethral prostatectomy.

This technique has evolved with us over the past 25 or more years and involves more than 4000 transurethral operations. Under low spinal anesthesia, often supplemented by a slow intravenous drip of sodium surital in 500 or 1000 cc, five per cent Dextrose, the prostate is resected in an orderly fashion down to the true capsule. (Figures 2,3,4)

Although there is a great variation in the appearance, size and shape of prostatic lobes before the operation, there is and should be little variation in the fossa of these same prostates at the completion of the prostatectomy. In other words one empty prostatic fossa looks similar to another empty prostatic fossa and later excretory urograms also demonstrate the absence of the prostate and the openness of the prostatic fossa. (Figures 5,6,7,8)



Left: Pre operative x-ray showing prostatic enlargement.

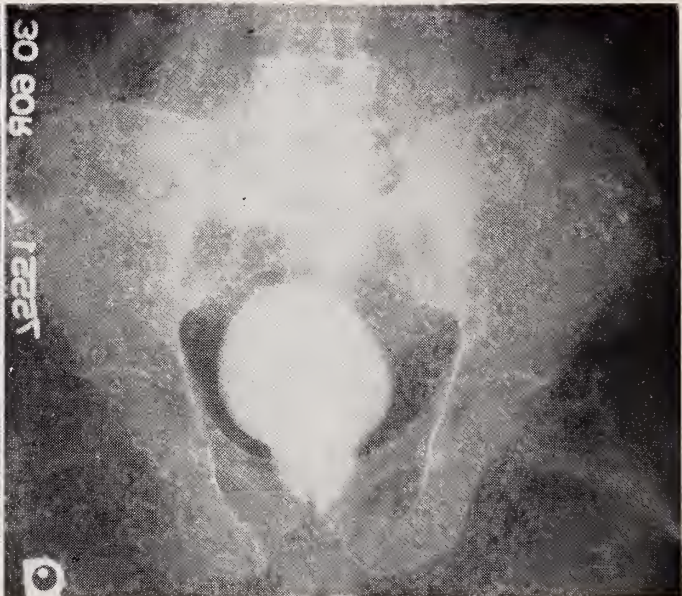
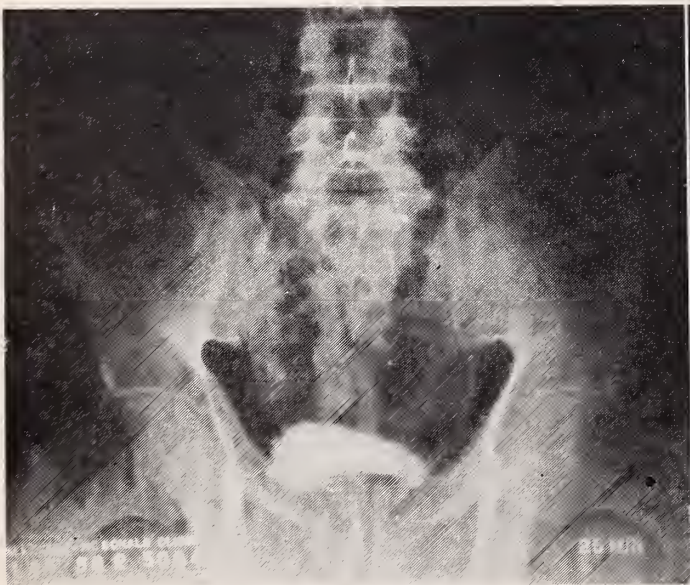


Figure 5
Right: Post-operative cystogram showing open prostatic fossa.



Left: Pre operative x-ray showing prostatic enlargement.

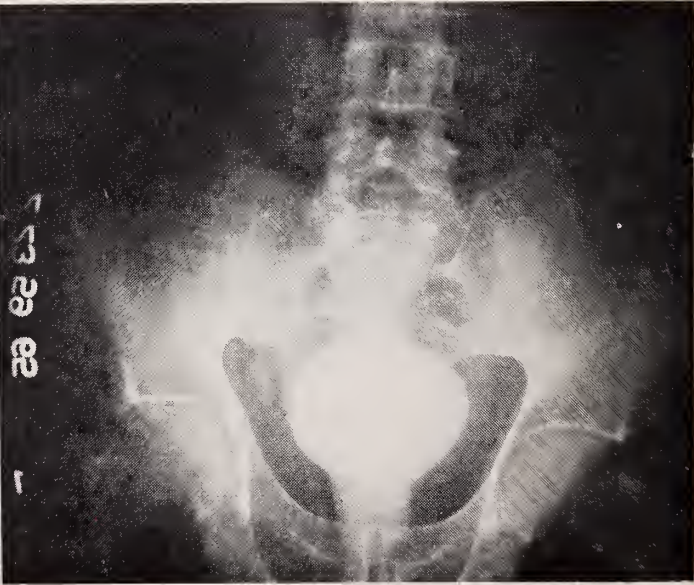


Figure 6
Right: Post-operative cystogram showing open prostatic fossa.



Figure 7

Left: Pre operative I. V. Urogram, note prostatic shadow.

Right: Post operative I. V. Urogram, note prostatic fossa.

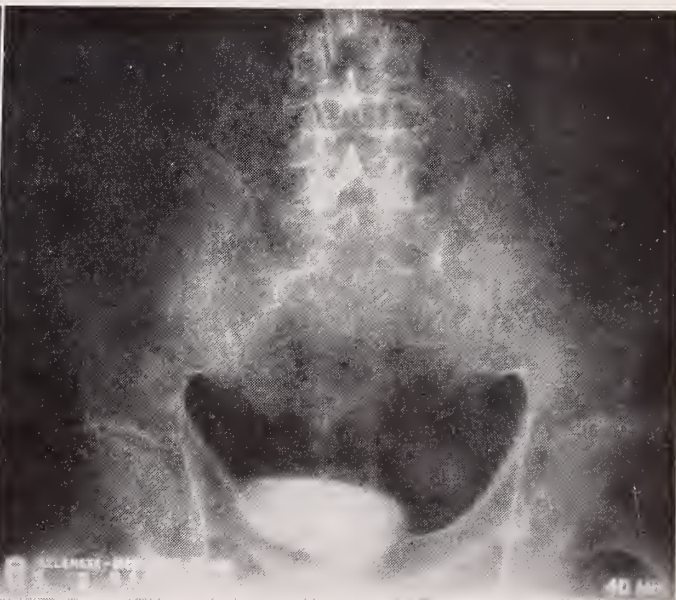


Figure 8

Left: Pre operative I. V. Urogram, note prostatic shadow.

Right: Post operative I. V. Urogram, note prostatic fossa.

In conclusion, I would like to be able to say that some easy way had been developed or discovered to perform or to learn transurethral prostatectomy but this is not the case. The many advances in medicine and surgery have nearly all been applied to improve the results and lessen dangers and complications of

transurethral surgery but the fact still remains that transurethral prostatectomy requires patience, skill and hard work for success. The end results are good and lasting if complete removal of obstructing tissue is carried out.

272 Ivy Street

BASIC SCIENCE LECTURES OFFERED

The Sisters of Mercy and the medical staff of St. Joseph's Infirmary will sponsor a series of basic science lectures in 1962. The lectures will take place in Woodruff Auditorium of St. Joseph's Infirmary at 5:30 on the dates indicated below:

February 12-16 Physiology of the Liver

March 19-23

May 7-11

June 11-15

Respiratory Physiology

Cardiovascular Physiology

Pathologic Physiology of
Arterial Diseases with
Application to Clinical
Problems

FIFTEEN YEARS' EXPERIENCE WITH EXTENDED PELVIC SURGERY

James F. Kirkpatrick, Jr., M.D.; Alexander S. Haraszti, M.D. and Sam A. Wilkins, Jr., M.D., *Atlanta*

■ ***At least 25 per cent of patients undergoing extended pelvic surgery should survive five years***

IT WAS IN SEPTEMBER, 1946, nearly 15 years ago, that the first pelvic exenteration in the United States was done by Dr. Alexander Brunschwig at Memorial Hospital in New York City. The senior author's experience began at that time while associated with that institution. The current series to be reported was begun in 1950 at the Robert Winship Memorial Clinic and Emory University Hospital and concerns the total experience to date with the pelvic exenteration operation. It has been our purpose to determine the place of extended pelvic surgery for advanced cancer within the pelvic. At the outset we felt that it would be possible to salvage with an acceptable morbidity and mortality a substantial number of patients, patients who would otherwise be without hope of surviving.

In a preliminary report¹ the senior author has outlined the historical background of pelvic exenteration, the surgical technique and the results to be expected. The definitions used for each type of exenteration are identical to those of Brunschwig² and may be summarized as follows: Total pelvic exenteration in the female consists of en masse excision of bladder, lower ureters, vagina, uterus, adnexae, rectum and lower sigmoid colon, and contiguous fatty tissue and dissectible lymph nodes in the pelvic. In an anterior pelvic exenteration the rectum and sigmoid colon are left intact while in the posterior pelvic exenteration the urinary tract is preserved intact. In the male the counterparts of exenterations are fairly obvious.

Extenerations for Carcinoma of the Cervix

During the 15-year period covered by this study 913 patients were seen in the Robert Winship

Memorial Clinic with epidermoid and adenocarcinoma of the cervix. Patients first seen between 1946 and 1950 were treated by conventional irradiation and failures from this group were considered for pelvic exenteration when seen after 1950. Forty-six patients have undergone pelvic exenteration, total, anterior, or posterior. Forty-one patients have been explored for extended pelvic surgery and found inoperable. At least 15 additional ones were offered extended pelvic surgery and refused. Of at least 27 patients for whom such surgery was considered but not offered a number received some benefit from radium, cobalt⁶⁰ or conventional irradiation therapy. Thorough evaluation of this latter group has not been completed.

Seven hundred and forty-eight patients were treated satisfactorily by conventional means or were hopelessly advanced when first seen.

During this time also 35 radical hysterectomies with dissection of the iliac, hypogastric and obturator nodes (unilateral or bilateral) were done. The average age of cervix cancer patients was 45.7 years. The mean parity was 2.5 children. Forty-four were white and three Negro. The major symptoms and signs present at the time of exenteration were pain in 26 patients, urinary symptoms in 21, gastrointestinal symptoms in 15, and bleeding in 23. It is of interest that 11 of 15 patients complaining of gastrointestinal symptoms required total pelvic exenteration. Twelve had been previously treated with both irradiation of some type (intracavitary radium, telecobalt, or conventional) and surgery.

Of 13 patients who had metastasis to lymph nodes three are living. One patient had a single positive broad ligament node and has survived 53 months. One patient with a positive hypogastric node is free of disease 33 months after surgery. The other patient

¹Presented at the 107th Annual Session of the Medical Association of Georgia, May 8, 1961, Atlanta, Georgia.

had only radionecrosis in the pelvic mass but one focus of carcinoma in an iliac node with invasion of the common iliac vein; she is now only three months after surgery.

Of the patients undergoing exenteration 30 had received irradiation alone, three surgery alone, and one definitive treatment. Twelve had had a combination of surgery and irradiation.

Total Experience

In addition to cervix cancer, pelvic exenteration has been done for four cases of adenocarcinoma of the rectum or rectosigmoid, one papillary and diffuse adenocarcinoma possibly of ovarian origin but just as likely of endometrial origin, one adenocarcinoma of the body of the uterus, and two carcinomas of the urinary bladder, a transitional cell papillary carcinoma and an epidermoid carcinoma. The results of these and cervical lesions are summarized in Table I.

TABLE I

Site of Primary	Number of Patients	Number Alive	Percent
Cervix	46	17	37
Rectum	4	3	75
Ovary*	1	1	100
Uterus	1	0	0
Bladder	2	0	0

*Some question of pathological diagnosis.

The "total surgical mortality," according to Brunschwig, includes all patients who died within 30 days of surgery. Two patients in our series fell into this category. One patient died in the hospital after 30 days. The "total hospital mortality" of this series then is three of 54 cases or 5.5 per cent (Tables II and III).

TABLE II
OPERATIVE MORTALITY

	Number	Percent
"TOTAL SURGICAL MORTALITY" (Within 30 days)	2	3.7
"HOSPITAL MORTALITY" (Over 30 days)	1	1.8
TOTAL (3/54 Cases)	3	5.5

TABLE III

Exenteration	Number	Operative Mortality	Per cent Mortality
"TOTAL"	31	3	9.1
"ANTERIOR"	20	0	0
"POSTERIOR"	3	0	0

(Estimated blood loss 2123 cc.)

The causes of these three mortalities were: intractable peritonitis with postoperative intestinal obstruction (two episodes) in addition to renal damage before surgery; pyelonephritis, acute and chronic with uremia (this patient had bilateral nephrostomies, renal shutdown and dialysis pre-operatively); and profound shock of undetermined etiology, but most probably due to mesenteric thrombosis (Table IV).

TABLE IV

CAUSES OF MORTALITY

PROFOUND SHOCK	1
(Possible Mesenteric Artery Thrombosis)	
PYELONEPHRITIS	1
(Acute and Chronic with Uremia)	
PERITONITIS AND REPEATED POST-OPERATIVE INTESTINAL OBSTRUCTION	1
TOTAL	3

Urinary Diversion

The urinary diversion techniques have been largely limited to the isolated sigmoid pouch or conduit (28 cases) and simple ureterosigmoidostomy (19 cases). Several of the latter group have been changed to an isolated rectal bladder because of severe infection, acidosis or both. This is done by merely dividing the lower sigmoid, closing the distal end and fashioning the proximal sigmoid into a left lower quadrant dry colostomy. A few have been constructed at the time of anterior pelvic exenteration.

The rectal bladder seems to serve as a satisfactory reservoir under voluntary control. Other advantages include low intraluminal pressure, a low infection rate, and usually the prevention of further damage to previously obstructed and infected kidneys. A collecting bag is unnecessary.

Severe hyperchloremic acidosis is confined largely to those patients with simple ureterosigmoidostomy although it does occur occasionally in patients with any type of conduit or reservoir. Three patients who died of pyelonephritis and uremia with no proved residual cancer had severe renal disease prior to surgery. The fourth patient, reported by the family doctor to have died from uremia and without known prior renal disease, had a sigmoid conduit. The types of urinary diversion and their major complications are summarized in Table V.

Discussion

The indications for these procedures are becoming better established as more data accumulate. The ideal candidate is the patient with carcinoma of the pelvic organs limited to the pelvis not extending to or invading the pelvic wall, movable, and without distant metastases, not amenable to limited surgery or which has not been cured by surgery or

TABLE V
LATE G-U COMPLICATIONS

Ureters in . . .	Sigmoid Conduit	Sigmoid Colon	Rectal Bladder	Other Ileocecocol Bladder Ideal Conduit Ureteroneocystostomy
NUMBER OF PROCEDURES	28	19	8	3
COMPLICATIONS	10	8	1	1
Recurrent Infection			(1)*	
Hydronephrosis	2	2	0	0
Hyperchloremic Acidosis	2	6	1	0
			(4)*	
Nephrectomy	2	0	(1)*	0
G-U Deaths (No residual cancer)	3	1	0	0

* = Residual from prior damage due to uretero-sigmoidostomies.

maximal irradiation. Extensive radionecrosis may be an adequate basis for extended surgery. When dealing with the older age group, patients over 65, one must weigh most carefully the various factors obtaining before undertaking surgery.

A careful explanation of the handicaps to be expected is made to each patient. Only those with a determination to live should be selected as this greatly facilitates their later adjustment to these problems. As was pointed out previously, 15 patients refused the surgery. It was not insisted upon and we feel that this is only right.

In general, we still feel that a procedure of this magnitude is not often justified as a palliative measure. Three types of pelvic cancers, those of the prostate, urinary bladder, and ovary, have rarely been eradicated by exenteration because of relatively early distant metastases or invasion of the pelvic wall or viscera beyond the scope of surgery. Our experience with bladder cancer corresponds to that of many others, i.e. if it is not curable by total cystectomy it is not curable by pelvic exenteration. Patients with positive para-aortic or common iliac nodes are rarely salvaged by the procedure.

While we readily admit that a tumor completely fixed by infiltration into the pelvic wall cannot be cured, it must be emphasized that often infiltration cannot be determined before surgery. Fixation may be more apparent than real from external examination. It is this group of patients which particularly taxes the judgment of the surgeon. Frequently he cannot determine until he has done considerable dissecting on the lateral wall of the pelvis and pelvic floor whether a tumor can be removed and then he

may have "burned his bridges" before he has determined that the pelvic wall is invaded. For this reason it has become our policy to complete as much of our dissection as possible before dividing the ureters and committing ourselves to a major excision.

Fifty-four patients have now been treated by partial or total pelvic exenteration. On the basis of the accumulated data we feel that these are justified procedures in properly selected patients. Exenterations can be carried out with a reasonable morbidity and mortality with a significant salvage (Table VI and VIII). Because of the many problems associated

TABLE VI
NON-FATAL OPERATIVE COMPLICATIONS
(G-U Infections Excluded)

FECAL FISTULAS	4
URINARY FISTULAS	3
INTESTINAL OBSTRUCTION	3
PELVIC ABSCESS	2
MYCARDIAL INFARCT	1
HEMORRHAGE (SEVERE)	1
ATELECTASIS	1
ACUTE ADRENAL INSUFFICIENCY	1
HYPOTENSION (SEVERE)	1
DIVISION OF OBTURATOR NERVE	1

TABLE VII
SURVIVAL RATES

5 + YEAR CLINICAL CURE	25.4%
(8 of 31 patients)	
AVERAGE LENGTH OF TIME OF SURVIVAL	17.4 Months

with the operative management of these patients as well as the selection of patients, it is felt that pelvic exenteration procedures should be done by those with considerable experience with the disease and the appropriate techniques, not by the occasional operator.

The salvaged patients are not invalids but can live useful lives with certain handicaps, mainly, loss of or quite limited sexual function, and the inconvenience of a colostomy or ureterostomy or both.

Despite the relatively low operative mortality we are convinced that we have not failed to offer surgery to any patient who could have been helped. We doubt that we can increase our salvage rate significantly. As we try to extend the operation to borderline cases we find a great incidence of failure to cure. Our five-year cure rate, which is somewhat disappointing to us, reflects our attempt to give each patient what possible chance of cure appeared to exist. In only the occasional patient, however, have we proceeded with exenteration then we felt cure was impossible and then only when we were convinced



Figure 1

that it had real palliative value. Yet one must proceed with the philosophy that this represents the patient's last and only chance to survive and not give up until one has proved incurability or inoperability.

While some workers experienced with pelvic exenteration procedures say categorically that anterior pelvic exenterations should never be done, our experience indicates that in a selected group the operation is justified. This is corroborated by some long-term survivors. Admittedly, however, one will cure more patients by a forthright total pelvic exentera-

tion. In certain instances anterior pelvic exenteration may be justifiably selected as a palliative procedure when one can preserve rectal function for control of either the fecal or urinary stream, one or both, with less "crippling" of the patient. The indications for a posterior pelvic exenteration are uncommon, particularly in regard to cervix cancer, and more often would be justified for extensive rectal cancer.

Fourteen of our 21 survivors are pictured in Figure 1.

Conclusions

1. Pelvic exenteration can be done with a reasonable morbidity and mortality rate ("total hospital mortality" 5.5 per cent).

2. Patients who have had extensive pelvic surgery can be comfortable, happy and useful.

3. The procedure is seldom justified for palliation.

4. A careful selection of patients should be exercised.

5. It is essential that these patients have a comprehension of their problem before surgery and a determination to live.

6. Urinary diversion remains one of the greater postoperative problems, for which there is no ideal solution.

7. At least 25 per cent of patients undergoing extended pelvic surgery should survive five years.

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GEORGIA CHOLESTEROL STUDY REPORTED

Population studies linking coronary heart disease and such factors as diet, heredity and occupational stress were reported to the American Heart Association's recent Scientific Sessions in Bal Harbour, Fla. Among the reports:

Trappist monks, who eat no meat, fish nor fowl, have about one-fifth as much heart disease as Benedictines who eat an average American diet, according to a research team from the Georgia Department of Public Health. The two groups of monks, comparable in most respects other than diet, have been studied since 1957 to determine whether diet influences the development of atherosclerosis (hardening of the arteries), the condition underlying most heart attacks. Although the prevalence of atherosclerotic complications was lower among the Trappists, according to the Georgia scien-

tists, additional studies have to be made before the difference can be attributed solely to the effects of diet.

Identical twins are much more alike than fraternal twins in blood levels of the fatty substance cholesterol, suggesting that these levels are at least partly determined by heredity, another Georgia team reported. Fifty-six pairs of twins were studied. Those who were identical twins, i.e., genetically the same, showed much more resemblance to each other in their cholesterol levels than did the fraternal twins. The latter are not necessarily more similar genetically than brothers and sisters. Since environmental influences could be more or less dismissed in the youngest group of twins, the investigators pointed out, the explanation for the difference between the two kinds of twins can best be explained in terms of heredity.

ACUTE RECURRENT INTUSSUSCEPTION

Pat Shea, Jr., M.D. and Avery L. Cotton, M.D., *Atlanta*

- ***A high index of suspicion is necessary in the management of children with abdominal pain who have had previous surgical procedures for reduction of intussusception***

MILD EPISODES OF ACUTE recurrent intussusception are apparently more frequent than are reported. It is also conceivable, from histories recorded, that in infants and young children the entity can exist without requiring a physician's attendance. Documented evidence of recurrent intussusception is believed to be less than two per cent of the cases^{1,2}. It is interesting, as is demonstrated in the report which follows, that acute recurrent intussusception may present only signs and symptoms of intermittent intestinal obstruction, rather than demonstrating the characteristic history and physical changes with which one is so familiar when establishing a diagnosis of intussusception in children.

Case Report

A white male, age 3½, weighing 27¾ pounds was admitted to St. Joseph's Infirmary on February 14, 1960 with a history of sudden onset of intermittent, colicky, abdominal pain, which began the day of admission. The colic was associated with nausea and vomiting, and a discharge of blood-streaked mucus and fecal material per rectum. No mass was palpable in the abdomen initially. Saline enemas administered prior to admission were streaked with blood of characteristic 'currant-jelly' appearance. The child had had a normal rate of growth and development; the only previous illnesses were the usual childhood diseases. He was noted on examination to have paroxysms of abdominal pain which lasted from one-half to two minutes in duration with quiescent intervals of 15 to 20 minutes between attacks. The abdomen was flat, hypoactive peristalsis was present, and an evanescent mass was palpable in the right mid-abdomen. There was some slight guarding

on the right, but only minimal tenderness. Sigmoidoscopy was not remarkable except for the appearance of blood mixed with mucus. The hemoglobin was 9.5, the hematocrit 31, the white count was 16,650 with a shift to the left. A barium enema revealed typical changes of intussusception, more particularly the coil-spring appearance of the ascending colon on the post-evacuation film. The remainder of the laboratory work was not remarkable. A pre-operative diagnosis of ileocolic intussusception was made and operation was performed. Approximately 15 centimeters of ileum had intussuscepted up to the mid-ascending colon region and this was reduced by taxis. The appendix was normal. The remainder of the exploration was not remarkable except for an associated acute lymphadenitis substantiated by biopsy and examination in the laboratory. The child was given 150 cc's. of whole blood intravenously during the operative procedure. His hospital course post-operatively was completely satisfactory, and he was discharged home on February 21, 1960.

He was seen at intervals during the first few months of the postoperative period and remained well.

Second Admission, July 25, 1960, St. Joseph's Infirmary: History revealed that five days prior to admission the patient developed cramping abdominal pain which was intermittent and produced some anorexia, but no nausea, vomiting or evidences of bleeding from the intestinal tract. He was treated symptomatically. He was seen again two days later by his attending physician and appeared to be in normal health. General examination was not remarkable and the impression was that he was recovering from a

rapidly subsiding enteritis (one sibling had gastroenteritis simultaneously). For the following two days the patient was well. Early on the morning of the day of admission, however, he developed severe pain, characterized by abdominal cramps and colic. Examination at this time revealed a right upper quadrant mass and associated mild abdominal tenderness, but was otherwise not remarkable. A flat plate of the abdomen was normal, but a barium enema revealed a radiological impression of colocolic intussusception with an ileal component.

Operation was performed through the original incision, and again an ileocolic intussusception existed and was reduced by taxis. Exploration of the peritoneal cavity failed to reveal any other abnormalities. The postoperative course was entirely satisfactory and he was discharged home on July 30, 1960. He has been seen at intervals since in follow-up and has been perfectly well.

Discussion

As mentioned previously, it is of interest and one should be aware that recurrence of intussusception requiring operative intervention can occur in the absence of characteristic findings; such as, vomiting exquisite tenderness, dehydration and the passage of blood or 'currant-jelly' clots per rectum. While admittedly, recurrent intussusception is a rarity, cognizance of this possibility will avoid morbidity or even, conceivably, mortality in a patient who would otherwise not accomplish reduction without intervention.

Intussusception itself³ is the most frequent cause of intestinal obstruction in childhood. It is primarily an illness of the first two years of life in an otherwise healthy, normal, well nourished child, males outnumbering females two to one. The etiology and pathogenesis of its occurrence is totally unrealized in 90 per cent of the cases studied. Associated abnormalities leading to its development may be such changes as Meckel's diverticulum, intestinal polyps, duplication of the intestine, congenital bands, hypertrophic mucosa at the ileocecal valve, etc.

Related changes in acute intussusception are classically described and identical to those that appeared on the first admission as presented in the case report.

Chronic, or clinically recurrent intussusception, however, may produce vague symptoms over a period of weeks or months and may appear to simulate those of intestinal obstruction. Thorndyke,² however,

has reported five cases of recurrent intussusception after previous operation which presented themselves with the same initial changes as at their original attack.

Recurrence of intussusception has occurred as early as 30 hours and as late as eight years.⁵ In one patient, four operations were required for reduction. In a series of 702 cases of intussusception reported by Ladd and Gross,⁵ approximately two per cent recurred, were re-operated, and all of these patients survived.

The treatment, if recurrent intussusception does not reduce spontaneously, is identical to that performed at an original procedure. Various reports^{1,2,3,4} recommend that if surgical intervention is necessary, only simple reduction be carried out unless, of course, some other abnormality; such as, a reduplication, gangrene, etc., exists.

Conclusions

Acute, recurrent intussusception, while admittedly rare, can and will deviate from the usual diagnostic criteria of acute intussusception. When it does, it usually appears in the form of either chronic, chronically recurrent, or an acute mechanical obstruction. For this reason, a high index of suspicion is necessary in the management of children with abdominal pain who have had previous surgical procedures for reduction of intussusception. Barium enema studies can be of inestimable value in the pre-operative evaluation of such a patient. It is the consensus of opinion that simple reduction should be carried out in cases of acute, recurrent intussusception requiring surgical intervention. The possibilities of a second or a third recurrence are extremely rare, and more radical operative procedures are not recommended.

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"It is hardly lack of due process for the Government to regulate that which it subsidizes."

Agricultural Adjustment Act, Supreme Court Decision, 1942. Justice Robert H. Jackson delivering the opinion of the majority.

GENERAL ANESTHESIA WITH HALOTHANE

John M. Brown, M.D., Atlanta

■ Experience with this agent in 2,890 operations is described

HALOTHANE (FLUOTHANE®) is a potent inhalation anesthetic drug synthesized in 1956 at the Imperial Chemical Industries' laboratory, Manchester, England. The chemical is a halogenated ethane (CF_3CHClBr) with a number of physical properties of interest to the anesthesiologist.

Soon after preparation, halothane was rapidly and thoroughly studied in laboratory animals¹ and in humans. Indeed, limited clinical trials of halothane were completed in England,² Canada³ and the United States⁴ within the following year. Most investigators felt that the new drug possessed enough desirable characteristics to warrant more extensive clinical trials in the human.

Halothane first became available at the Crawford W. Long Memorial Hospital in 1958. Accurately calibrated vaporizers were obtained, and the first anesthesia with halothane was administered on August 16, 1958.

The use of halothane for inhalation anesthesia has steadily increased, and today, it occupies a very prominent position among other anesthetic drugs at the Crawford W. Long Memorial Hospital. Throughout the past 32 months, 4,013 operations have been performed with halothane anesthesia. In March 1961, halothane was used in 56 per cent of the total inhalation anesthetics (Figure 1).

The purpose of this article is to report the use of halothane as the sole or primary anesthetic agent, often in combination with a muscle relaxant drug, for 2,890 abdominal operations.

Methods of Administration

Patients were premedicated according to well-established principles of premedication. Eighty-seven patients between the ages of 16 hours and 25 months received atropine alone, and 2,803 patients received a narcotic plus an anticholinergic drug. Ninety-two patients received an ataractic drug as a part of the regimen in addition to a narcotic and anticholinergic drug.

Essentially, the anesthesia technique employed intravenous sodium thioamylal (Surital®) to produce unconsciousness in most adults and some children. With the loss of consciousness, a mixture of nitrous oxide-oxygen was given with a semi-closed, circle, carbon dioxide absorption technique. Halothane was added gradually to the nitrous oxide-oxygen mixture from a halothane vaporizer until the desired depth of anesthesia was attained.

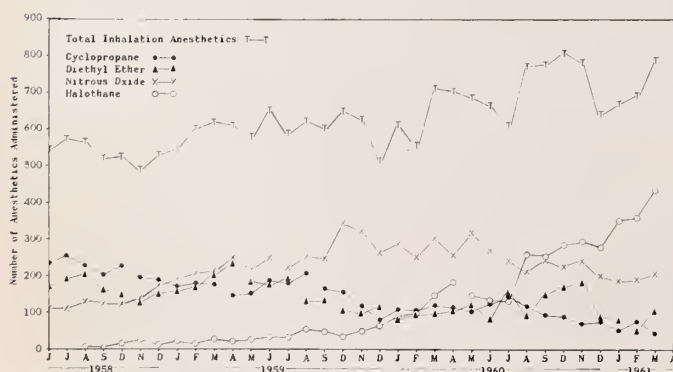
A muscle relaxant drug was administered, intravenously, when endotracheal intubation or additional muscular relaxation was desirable.

Respiratory assistance or complete, manual respiratory control was instituted as necessary throughout anesthesia.

The drugs and techniques employed for inducing and maintaining anesthesia are listed in Figure 2.

Detailed anesthesia and operative records were maintained on each patient. The anesthetist recorded the premedication, the course of anesthesia and operation, the drugs administered for and during anesthesia, and the quality of muscular relaxation achieved. Vital signs were monitored by standard clinical techniques. Halothane concentrations were obtained directly from the factory calibrations on the vaporizer or from a nomogram supplied by the

FIG. 1 GENERAL ANESTHESIA WITH HALOTHANE
Crawford W. Long Memorial Hospital
Atlanta, Georgia
1958-1961



Presented at the 107th Annual Session of the Medical Association of Georgia, May 8, 1961.

FIG. 2 ANESTHESIA TECHNIQUES WITH HALOTHANE
2,890 Abdominal Operations

INDUCTION OF ANESTHESIA		MAINTENANCE OF ANESTHESIA	
1. Sodium Thioamylal, 2.5% Intermittent, I.V.	2,065		
2. Sodium Thioamylal, 0.4% Drip, I.V.	613		
3. Inhalation Anesthetic Agts. (A) Diethyl Ether, Open Drop	26	1. Semi-closed, CO ₂ Absorption Technique with 2.0L N ₂ O-15 to 2.0L O ₂ * 2,720	1. Semi-closed, CO ₂ Absorption Technique with 2.0L N ₂ O-15 to 2.0L O ₂ * 2,721
(B) N ₂ O-O ₂ , semi-closed & non-rebreathing	19	2. Non-rebreathing Technique with 3.0 to 4.0 L N ₂ O-3.0 to 4.0 L O ₂ * 105	2. Non-rebreathing Technique with 3.0 to 4.0 L N ₂ O-3.0 to 4.0 L O ₂ * 106
(C) Cyclopropane, semi-closed & non-rebreathing	31	3. Insufflation Technique with 2.0L N ₂ O-15 to 2.0L O ₂ * 4	3. Insufflation Technique with 2.0L N ₂ O-15 to 2.0L O ₂ * 4
(D) Diethyl Ether, open drop	3	4. Open Drop Mask Technique with O ₂ 61	4. Open Drop Mask Technique with O ₂ 59
(E) Halothane, open drop, semi-closed* & non-rebreathing*	91		
4. Sodium Thiopental, Rectal	40		
5. Local Anesthesia	2		
TOTAL	2,890	TOTAL	2,890

* VAPORIZERS: HEIDBRINK VERNITROL, F.N.S., HEIDBRINK FLUOTHANE, FLUOTEC, OR FOREGGER COPPER KETTLE

manufacturer of the vaporizer. These were not alveolar concentrations of halothane.

The ages of 2,890 patients who had abdominal operations varied from 16 hours to 91 years with the greatest distribution between four-48 years. The times of anesthesia ranged from ten minutes to 9.5 hours. Operations were classified as thoraco-abdominal (19), high, mid or low abdominal (1,563), pelvic (972), extraperitoneal (34) and inguinal (302). Approximately 96 per cent were classed as major operations and four per cent were classed as minor operations.

Results and Discussion

Induction of anesthesia with the sodium thioamylal, nitrous oxide-oxygen, halothane sequence presented no unusual difficulties. Dosages of sodium thioamylal varied from 75 mgs. in a child to 825 mgs. in a large adult with a history of chronic alcoholism. Most adults required 250 to 375 mgs.

Halothane was added without excessive salivation, coughing or laryngospasm by slowly increasing the vapor concentration in small increments from 1.0 per cent toward 2.5 per cent. Surgical anesthesia ensued within five to seven minutes with a mean halothane concentration of 1.6 per cent (s.d. \pm 0.3).

When halothane was employed as the sole anesthetic drug for induction, with or without nitrous oxide-oxygen in a semi-closed or non rebreathing technique, a mean halothane concentration of 2.4 per cent (s.d. \pm 0.2) was employed to affect a more rapid and smooth induction of anesthesia.

The halothane vaporizer was adjusted to provide a maintenance level of anesthesia after attaining the desired depth of surgical anesthesia. This vapor concentration varied widely around a mean halothane concentration of 1.1 per cent (s.d. \pm 0.4).

These halothane concentrations are higher than those successfully employed by Smith and Volpito⁵; they fall within the range of clinical concentrations reported by Stephen, *et. al.*⁶ Such inherent factors as temperature of the halothane, level of halothane in the vaporizer, duration of anesthesia, depth of

anesthesia maintained during operation and calibration deviations of the vaporizer could produce variability between these data.

Hudson, *et. al.*,⁷ found that vapor concentrations of halothane which produced good or excellent abdominal muscle relaxation also produced an alarming degree of respiratory and circulatory depression. These observations, in effect, led to the use of lower clinical concentrations of halothane and the simultaneous use of adjunctive muscle relaxant drugs.

In this study of 2,890 patients, 92.0 per cent received muscle relaxant drugs in addition to the inhalation anesthesia. Figure 3 shows the initial doses and total doses of five curarimimetic drugs during 2,198 abdominal operations.

FIG. 3 HALOTHANE & MUSCLE RELAXANT DRUGS
2,196 Adult Patients*; 2,198 Abdominal Operations

Relaxant Drug	No. Oper.	Initial Dosage (Mg.)		Total Dosage (Mg.)	
		mean(x)	s.d. (s)	mean(x)	s.d. (s)
Succinylcholine chloride					
0.2%, I.V., drip	1,001	89.1	\pm 9.2	718.3	\pm 161.0
2.0%, I.V., intermittent	136	47.5	\pm 6.0	82.4	\pm 14.5
d, Tubocurarine chloride	938	13.8	\pm 1.7	14.6	\pm 1.9
Mediatonal®	51	18.4	\pm 1.5	19.2	\pm 1.3
Dimethyl tubocurarine chloride	34	4.0	\pm 0.7	5.3	\pm 0.6
Decamethonium bromide	38	2.9	\pm 0.2	5.4	\pm 1.3

* Excluded: 446 patients, Age 0 - 14 yrs., and 17 patients, incomplete records.

Succinylcholine chloride and decamethonium bromide produce muscle relaxation by depolarizing the myoneural junction. These "depolarizing" drugs reacted in the same manner with halothane as they do with other anesthetic drugs.

Mediatonal® (1,2 bis (p-trimethylammonium-ethoxyphenyl)—3-methyl butane diiodide), dimethyl tubocurarine and d, tubocurarine are "non-depolarizing" muscle relaxant drugs. Of the three, d, tubocurarine has the greatest autonomic ganglioplegic effect.⁸ Because of this action, a precipitous hypotension which appeared in some patients has been attributed to the halothane -d, tubocurarine combination.

1,023 adult patients received a "non-depolarizing" muscle relaxant drug during halothane anesthesia. The mean initial dosages and the mean total dosages of each of these three "non-depolarizing" drugs were smaller than those usually employed during anesthesia with nitrous oxide, alone, yet larger than the doses employed during anesthesia with diethyl ether. Other investigators have observed that halothane intensifies the neuromuscular action of d, tubocurarine.⁹

No significant complications arose during the use of Mediatonal® or dimethyl tubocurarine with halothane in this series of patients. However, certain repeated observations during the use of d, tubocurarine and halothane are of interest to the anesthesiologist.

The blood pressure and pulse rate were remarkably steady during anesthesia. The slowest pulse

rate was 52; additional atropine was never necessary because of bradycardia. Autonomic reflex changes in the blood pressure were not prominent during abdominal manipulations. Few cardiac arrhythmias were detected during anesthesia. In fact, three benign arrhythmias, present pre-operatively, were not observed after induction of anesthesia nor in the immediate post-operative period.

No post-anesthesia apnea was encountered. Tensionlon® was administered to four patients near the end of the operation to antagonize the effect of *d*, tubocurarine on the depth of respiration. One patient had required profound muscular relaxation for closure of the abdomen, and three patients required less extensive surgery than was anticipated.

Assisted respiration or complete manual control of respiration was performed at some time during 81.4 per cent of all 2,198 adult operations. Respiratory assistance or control was necessary in only 49.7 per cent of the 1,023 adult operations in which the "non-depolarizing" muscle relaxant drugs were employed.

The blood pressure level proved to be a reliable clinical index of circulatory function. The degree of hypotension observed in 2,890 abdominal operations paralleled that observed by Stephen, *et. al.*,¹⁰ and appeared to be related closely to the concentration of halothane. Mild hypotension was usually reversed by diluting the halothane-nitrous oxide mixture, and was not significantly increased by dosages of the curarimimetic drugs which were necessary to provide good or excellent abdominal muscle relaxation. Indeed, an alarming degree of hypotension (systolic below 50 per cent of pre-operative level) was observed in only six patients of 938 who received *d*, tubocurarine chloride. Two of these episodes occurred after the administration of single doses of 21 mgs. of *d*, tubocurarine. Herein, dilution of the halothane-nitrous oxide mixture and the use of small doses of methoxamine or phenylephrine, I.V., promptly elevated the blood pressure to pre-existing levels.

The autonomic ganglioplegic action of *d*, tubocurarine is apparently responsible for some of these observations. The dosages of *d*, tubocurarine and concentrations of halothane which will produce satisfactory abdominal relaxation can also produce a stabilizing effect on the heart rate and on the blood pressure through partial parasympathetic ganglionic blockade. The sympathetic ganglioplegic effect of this combination which is responsible for the reported hypotensive episodes possibly appears only

with a dosage-concentration range higher than that necessary for clinical utilization. Guyton and Reeder¹¹ found this to be true in their study of the autonomic nervous system of the dog.

No histamine effects were observed from the use of *d*, tubocurarine and halothane in patients with a history of asthma, a history of contact allergy or a history of hay fever.

One death occurred during operation from massive pulmonary fat embolization, and four deaths occurred in the post-operative period from advanced carcinomatosis (2), coronary thrombosis (1) and pulmonary embolus (1). These were confirmed at autopsy.

Summary

Halothane was employed as the sole or principal inhalation anesthetic drug for 2,890 abdominal operations. Ninety-two per cent of these patients received one of five adjunctive muscle relaxant drugs during anesthesia.

The concentration-dosage range of halothane, nitrous oxide-oxygen, *d*, tubocurarine anesthesia which was satisfactory for 938 abdominal operations did not produce the precipitous hypotension which might be expected to occur on the basis of early clinical studies with halothane and *d*, tubocurarine.

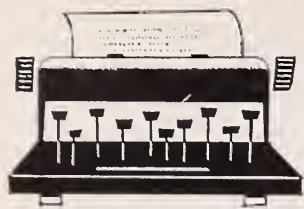
Crawford W. Long Memorial Hospital

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NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Andrew, John R.	2701 N. Decatur Rd. Decatur, Georgia	DE 2	DeKalb
Arnold, Joseph A.	2701 N. Decatur Rd. Decatur, Georgia	DE 2	DeKalb
Barksdale, John H., Jr.	41 S. Main Street Statesboro, Georgia	Active	Bulloch, Candler, Evans
Brockman, John L.	Emory University Hosp. Atlanta 22, Georgia	DE 2	Fulton
Busey, Thomas J., Jr.	69 Butler Street, S. E. Atlanta 3, Georgia	DE 2	Fulton
Cable, Robert, II	Dept. of Psychiatry Eugene Talmadge Mem. Hosp. Augusta, Georgia	DE 2	Richmond
Campbell, Robert E.	Veterans Administration Hosp. Augusta, Georgia	Active	Richmond
Carrington, Kenneth W.	1021 15th Street Augusta, Georgia	Active	Richmond
Copelan, Elton L., Jr.	265 Ivy Street, N. E. Atlanta 3, Georgia	DE 2	Fulton
Dodd, Robert H.	Emory University Hosp. Atlanta 22, Georgia	DE 2	Fulton
Graham, Charles A.	35 Linden Avenue, N. E. Atlanta 8, Georgia	DE 2	Fulton
Knight, Evelyn A.	2646 Gresham Rd., S. E. Atlanta 16, Georgia	Active	DeKalb
Long, Crawford W.	384 Peachtree St., N. E. Atlanta 8, Georgia	Active	Fulton
McCall, Marvin M., III	69 Butler St., S. E. Atlanta 3, Georgia	DE 2	Fulton
Morris, John W., III	Emory University Hosp. Atlanta 22, Georgia	DE 2	Fulton
Pool, Winford H., Jr.	Eugene Talmadge Mem. Hosp. Augusta, Georgia	Active	Richmond
Sanchez-Moreno, H. L.	157 Peachtree St., N. E. Atlanta 3, Georgia	Active	Fulton
Shanks, James Z.	80 Butler St., S. E. Atlanta 3, Georgia	Active	Fulton
Swartwout, Joseph R.	69 Butler St., S. E. Atlanta 3, Georgia	DE 2	Fulton
Thurman, William G.	69 Butler St., S. E. Atlanta 3, Georgia	Active	Fulton
Tillman, Samuel P.	302 Donehoo Street Statesboro, Georgia	Active	Bulloch, Candler, Evans
Walker, John W.	558 Medlock Road Decatur, Georgia	Active	DeKalb



The Diagnosis of Surgically Curable Hypertension

THE TWO MAIN clues in the history that lead to the suspicion of an unusual form of hypertension that may be surgically cured are:

- (1) An unusual age of onset of hypertension.
- (2) The lack of a family history of hypertension or its complications.

Essential hypertension usually begins at about age 30 and in 25-50 per cent of cases is associated with a family history in one parent or sibling. Therefore the discovery of hypertension in an 18 year old (without kidney disease) or the onset of hypertension in a 50 year old (with previous known normal blood pressure) is an important clue that one may be dealing with unilateral renal artery obstruction, a pheochromocytoma, an adrenal tumor producing aldosterone or coarctation of the aorta. Of course any of these conditions may also first appear during the 25 to 40 age period, and then the "age of onset clue" may be misleading.

Since the majority of workers in the field of essential hypertension suspect that this is a hereditary tendency—the absence of any family history should raise the suspicion in the physician's mind that this may be secondary hypertension and it may be surgically correctible.

Specific clues from the history that are not always, but may be present, are:

- (1) Pheochromocytoma—excess sweating, weight loss, paroxysmal headache.
- (2) Aldosteroma—polyuria, polydipsia, transient weakness or paralysis, tetany, and intolerance to thiazide diuretics.
- (3) Unilateral Renal Disease—history of back or abdomen trauma with hematuria, unexplained acute abdominal pain often with transient azotemia, fever and chills or hematuria.
- (4) Coarctation—rarely intermittent claudication of the lower extremities.

The physical examination of all hypertensives should include:

- (1) The measurement of blood pressure in all four extremities.

- (2) The measurement of blood pressure supine and standing.
- (3) Careful examination of the optic fundi.
- (4) Estimation of heart size.
- (5) Auscultation of all major vessels (carotids and femorals) and especially the abdomen and renal areas.
- (6) Careful palpation of the kidneys for abdominal tumors.

In coarctation the diagnosis can be established by the physical examination. Besides low blood pressure in the lower extremities, visible pulsation and murmurs over the collateral vessels between the ribs along the back or lateral thoracic cage may be present. In pheochromocytomas, about 20 per cent have postural hypotension and about 20 per cent have a palpable abdominal tumor.

In renal artery occlusive disease, a systolic bruit may be heard over the abdomen or renal area. Bruits indicating carotid or femoral artery obstruction may hint at severe arteriosclerotic disease that also involves the kidney.

The routine laboratory examination of the hypertensive patient should include:

- (1) Urinalysis.
- (2) PSP excretion or BUN.
- (3) K and CO₂ measurements.
- (4) Chest X-ray and Electrocardiograph.
- (5) KUB or IVP Roentgenograms.

A negative urinalysis rules out chronic renal disease in a young, severe hypertensive and the chances of this being secondary hypertension (renal artery, pheochromocytoma, etc.) are greatly increased. A low specific gravity and a high urinary pH are clues to aldosteroma. Albuminuria, pyuria, and casts, especially red cell casts, are indicative of parenchymal renal disease and except for aldosteroma, make the chance of this being curable hypertension *unlikely*. A low serum potassium and a high CO₂ (in the absence of chlorothiazide diuretics) strongly suggests aldosteroma.

In unilateral renal artery obstruction, the urinalysis, PSP, BUN and IVP are usually entirely

normal. Small differences in kidney size or function on intra-venous pyelography may be the only clue.

Special tests are indicated whenever suspicions are raised by any of the preceding clues from history, physical examination or routine laboratory studies.

The Regitive test is safe and simple to perform in the office when the blood pressure is over 160/100 in a patient suspected of pheochromocytoma. The histamine test is the most reliable provocative test in case of paroxysmal hypertension. It is important that Regitime be available to control excessive pressor responses and adrenalin be available for bronchospasm or anaphylaxis. Histamine should be avoided in the elderly or arteriosclerotic patient.

The most difficult form of curable hypertension to detect is unilateral renal disease. The safest and most definitive procedure in my opinion is aortagra-

phy with visualization of the renal arteries. Differential renal function tests using retrograde ureteral catheterization (Howard Test) may be of help but are difficult to perform and evaluate. Certainly if there is any suspicion of bilateral renal disease, differential function studies should be done before a kidney is removed.

In summary, before making the diagnosis of "essential hypertension" and subjecting the patient to a lifetime of taking expensive and sometimes unpleasant medicines, the physician should review in his mind the known curable forms of hypertension and decide which of the above studies are needed in each individual case. In the majority of cases a good history, physical examination, and routine laboratory studies are all that is necessary.

Joseph A. Wilber, M.D.

Kerr-Mills Law Activated in Georgia

THE PROFESSION'S solution to this problem of Health Care of the Aged becomes effective in Georgia on January 1, 1962 under the provisions of our Medical Assistance to the Aged Act (Kerr-Mills Law). This is the program that makes health care available to those older people that actually need such care. This is the program that is administered at the state level; not by federal decree. And is the program that will be co-administered by the profession itself through its state medical association by providing medical determination and consultative services to the State Department of Public Welfare.

As each physician is the key control in determining patient's medical need for hospitalization—the doctor must know the "ground rules" prior to his exercise of medical judgment. Complete rules and regulations of the program will be found in this issue of *JMAG*, but simply put the program provides hospital care for an up to 10 day period per admission; 30 day maximum per year. Such patients must be certified by Welfare for eligibility—and must be certified by the physician's signature as having an *acute illness or injury or exacerbation of an acute illness or injury that can only be treated within a hospital*.

While nursing home care will also be covered by the provisions of this program, these regulations will be administrated directly by the Department of Public Welfare—hence these regulations are not within the jurisdiction MAG.

Because of the unknown incidence of the need for such patient care as this program encompasses, only

hospital care and certain nursing home care will be provided initially. As experience is gained, perhaps the program can be broadened to give other health care benefits—depending on available state funds and the extent of utilization. Physicians are cautioned to use careful consideration in applying limitations—so that this program may give such health care only when it is essential the patient have such health care. This program will serve the community best through utilization based on "acute and emergency or injury—and to that end MAG will assist the Department of Welfare in the processing of hospital claims to determine that:

- (1) the illness or injury comes within the scope of the program of hospital care;

- (2) the length of stay in the hospital is commensurate with the diagnosis.

So that accurate studies of the program's benefits may be undertaken, physicians are urged to clearly indicate the admitting diagnosis; the surgical procedure, if any; and the final diagnosis using the standard nomenclature as published by the AMA. This will also facilitate prompt payment of hospital claims.

MAG has accepted this responsibility to serve with state government and again prove that the profession itself is the authority in the field of patient care and that local jurisdiction by state and county provide the most efficient and economical service.

Certainly then it is up to the practicing physician to make this program work.

John T. Mauldin, M.D.

The Nation-Wide Medical Self-Help Training Program

UNDER THE GUIDANCE of the American Medical Association and the U. S. Public Health Service, plans are now under way in Georgia and across the nation for the introduction and promotion of the "Medical Self-Help Training Program," a new program designed to teach American families how to survive a national emergency and meet their own health needs, if a physician is not available.

Under active leadership of the AMA the Self-Help program—designed and introduced by the U. S. Public Health Service—is built around the basic information a person should know to preserve life and health in time of natural or man-made disaster. The AMA is actively endorsing the training and entering into its promotion to the American public. The Medical Association of Georgia is implementing professional leadership of the program in this State under the guidance of its Committee on Disaster Medical Care.

The Medical Self-Help Training Program was tailored to civil defense and other disaster needs. As such it has considerable merit. However, to become an actual success it must have the support and cooperation of local physicians.

Underlying the Medical Self-Help Training concept is the philosophy that "knowledge replaces fear." A person who knows what to do when faced with disaster will act rationally and effectively. One who is unlearned and fearful will react blindly and ineffectually. The training program will teach people confidence in their ability to survive, along with the skills to make them self-reliant until they can obtain a physician's services.

The program consists of two parts: one, a reference manual; and two, a formal training course.

Part I—Family Guide—Emergency Health Care— is a manual for the American family which contains instructions for survival and emergency health care if a physician or organized health services are not available for several days to weeks. The Committee on Disaster Medical Care of the Council on National Security of the American Medical Association assisted and advised the U. S. Public Health Service in its development. The Family Guide covers the same general topics as are indicated following for the Medical Self-Help Training Kit. The kit and the course in Medical Self-Help Training are based on the survival and health care principles contained in the Family Guide. Every effort has been made to

present all material in simple, non-technical terms, which are readily understandable.

Part II—The Medical Self-Help Training Kit— contains everything needed for teaching: instructors guide; printed instructors lesson folders with color film-strip illustrations; projector and screen; lamp and pointer; student handouts; test forms; and graduation certificates. The kit is packaged in a heavy-duty, moisture proof solid fiber box. It has a carrying handle and weighs approximately 20 pounds. Copies of the Family Guide—Emergency Health Care are furnished for instructor and students. The course is taught in 16 hours—usually eight two-hour sessions. The subjects are: radio-active fall-out and shelter; hygiene, sanitation and vermin control; water and food; shock; bleeding and bandaging; artificial respiration; fractures and splinting; transportation of the injured; burns; nursing care of the sick and injured; infant and child care; and emergency childbirth.

During 1961 the kits were given an initial testing in the Greater Atlanta Area under the supervision of the Public Health Service and the State and Local Health Departments and the Committee on Disaster Medical Care of the Medical Association of Georgia prior to being approved for large-scale production.

Groups testing the kits included a girl scout troop; teen-age high school students; employees of the Citizens and Southern Bank; a pharmaceutical house; a parent-teacher association; two groups of state employees; the Woman's Auxiliary of the Medical Association of Georgia; a church group; the professional staff of the DeKalb County Health Department; and a group of teen-age boys at the Georgia Baptist Children's Home. In all groups except two (the Bank and the Health Department), the instructors were lay people teaching lay audiences, but under professional supervision. Kits will be available to selected groups in Georgia early in 1962.

Implementation of the program has been discussed by representatives of state medical societies, state offices of civil defense, state health departments, and state offices of education at three workshops held in Brooklyn, N. Y., October 16-19; Alameda, California, November 19-22; and Battle Creek, Mich., December 4-7, 1961. The workshops were co-sponsored by the Public Health Service and the American Medical Association. The following persons represented Georgia at a workshop:

Lester M. Petrie, M.D., Georgia Department of Public Health;

Mr. Jack Grantham, State Civil Defense;

John P. Wilson, M.D., Medical Association of Georgia;

James Owen, Ph.D., State Department of Education;

Mrs. Kels Boland, Women's Auxiliary, Medical Association of Georgia;

Mr. George Watson, Georgia Department of Public Health.

These individuals have been organized as an advisory committee under the chairmanship of Dr. Edgar Dunstan, Chairman of the Committee on Disaster Medical Care of the Medical Association of Georgia. The function of this advisory committee is to develop a written plan describing the operational program it recommends to be used in the state. This plan,

when approved by the State Civil Defense Director, will determine the method by which the various federal and national agencies may assist the states in the program. The recommendations of this Georgia committee will be published in an early issue of the Journal of the Medical Association of Georgia.

Each person attending the workshops has been issued a training kit. Now that the workshops are completed, additional kits will be made available soon through the Georgia Department of Public Health and in accordance with the plans as worked out by the advisory committee and approved by the State Civil Defense Director. For further information on the program contact the Georgia Department of Health or the Disaster Medical Care Committee of the Medical Association of Georgia.

*Edgar M. Dunstan, M.D.
Committee on Disaster Medical Care*

One Man's Meat Is Another Man's Poison

MANY NEW DRUGS are appearing every year and it is very difficult for the busy practitioner to become acquainted with their therapeutic and toxic effects. The drug "detail man" minimizes the possible ill effects of his product. The doctor has little or no time for reading scientific articles about drugs, and he does not recognize the chemical names under which they are discussed. These potent new drugs often have serious toxic effects which the practitioner discovers too often at the expense of his patients.

The following is a partial alphabetical list of the types of drugs for which new products have been presented to the writer in the past year:

Anabolic agents, analgesics, anorexiant, anti-arthritis, antibiotics, anti-coagulants, anti-convulsants, anti-depressives, anti-histamines, anti-hypertensives, anti-nauseants, anti-Parkinson drugs, blood clotting agents, bronchodilators, cardiac drugs, diagnostic agents (x-ray media), diuretics, estrogens, fungicidal agents, muscle relaxants, narcotics, nasal decongestants, oral hypoglycemic agents, phenothiazines, steroids, sympathomimetics, thrombolytics, tranquilizers, urinary antiseptics, vasodilators, vasoconstrictors.

In a single 12-month period the writer has seen toxic reactions to various drugs from the above list as follows:

Addiction, anorexia, asystole, bleeding, blurred vision, breast tenderness, cardiac arrhythmia, cerebral thrombosis (from collapse), collapse, coma, convulsions, dehydration, dermatitis, diarrhea, drowsiness, dry mouth, edema, excitement, extrapyramidal symptoms, falling, forgetfulness, gastro-enteritis, giddiness, granulopenia, headache, hemolytic ane-

mia, hepatitis, homologous serum jaundice, hypochloremia, hypoglycemia, hypokalemia, hyponatremia, ileus, intravascular thrombosis (from collapse), iodism, menorrhagia, mental confusion, muscular weakness, myocardial infarction (from collapse), nausea, necrosis of tissue, osteoporosis, Parkinsonism, peptic ulceration, pruritus, respiratory depression, respiratory paralysis, shock, skin rash, somnolence, syncope, tachycardia, urticaria, vertigo, visual symptoms, vomiting, weight gain, withdrawal symptoms.

A doctor with a busy practice is apt to see every symptom in this list in a single year, some repeatedly.

The practitioner has a moral duty and a legal compulsion to learn all he reasonably can about a drug before prescribing it. He should demand that the "detail man" provide complete information about all known and potential toxic effects of his product. If unexpected symptoms occur in a patient taking the drug, he should stop it at once and consult the medical literature, an internist, a pharmacologist, or even the manufacturer about a possible "side effect" of the drug. He has a responsibility also to the profession and to the public to record the observed toxic effects and to publish this information or transmit it to someone else who will.

"Side effects" are real chemical, biological, metabolic, pharmacological, serological, or allergenic effects of the drug. In the individual case, the so-called "side effect" may be the principal pharmacologic effect because of biological peculiarities of the individual. Therefore, it is wise to prescribe only small amounts of a new or a potentially toxic drug.

blood pressure approaches normal more readily, more safely....simply with **Salutensin[®]** (hydroflumethiazide, reserpine, protoveratrine A—antihypertensive formulation)

Early, efficient reduction of blood pressure. Only Salutensin combines the advantages of protoveratrine A ("the most physiologic, hemodynamic reversal of hypertension"¹) with the basic benefits of thiazide-rauwolfia therapy. The potentiating/additive effects of these agents²⁻⁸ provide increased antihypertensive control at dosage levels which reduce the incidence and severity of unwanted effects.

Salutensin combines Saluron[®] (hydroflumethiazide), a more effective 'dry weight' diuretic which produces up to 60% greater excretion of sodium than does chlorothiazide⁹; reserpine, to block excessive pressor responses and relieve anxiety; and protoveratrine A, which relieves arteriolar constriction and reduces peripheral resistance through its action on the blood pressure reflex receptors in the carotid sinus.

Added advantages for long-term or difficult patients. Salutensin will reduce blood pressure (both systolic and diastolic) to normal or near-normal levels, and maintain it there, in the great majority of cases. Patients on thiazide/rauwolfia therapy often experience further improvement when transferred to Salutensin. Further, therapy with Salutensin is both economical and convenient.

Each Salutensin tablet contains: 50 mg. Saluron[®] (hydroflumethiazide), 0.125 mg. reserpine, and 0.2 mg. protoveratrine A. See Official Package Circular for complete information on dosage, side effects and precautions.

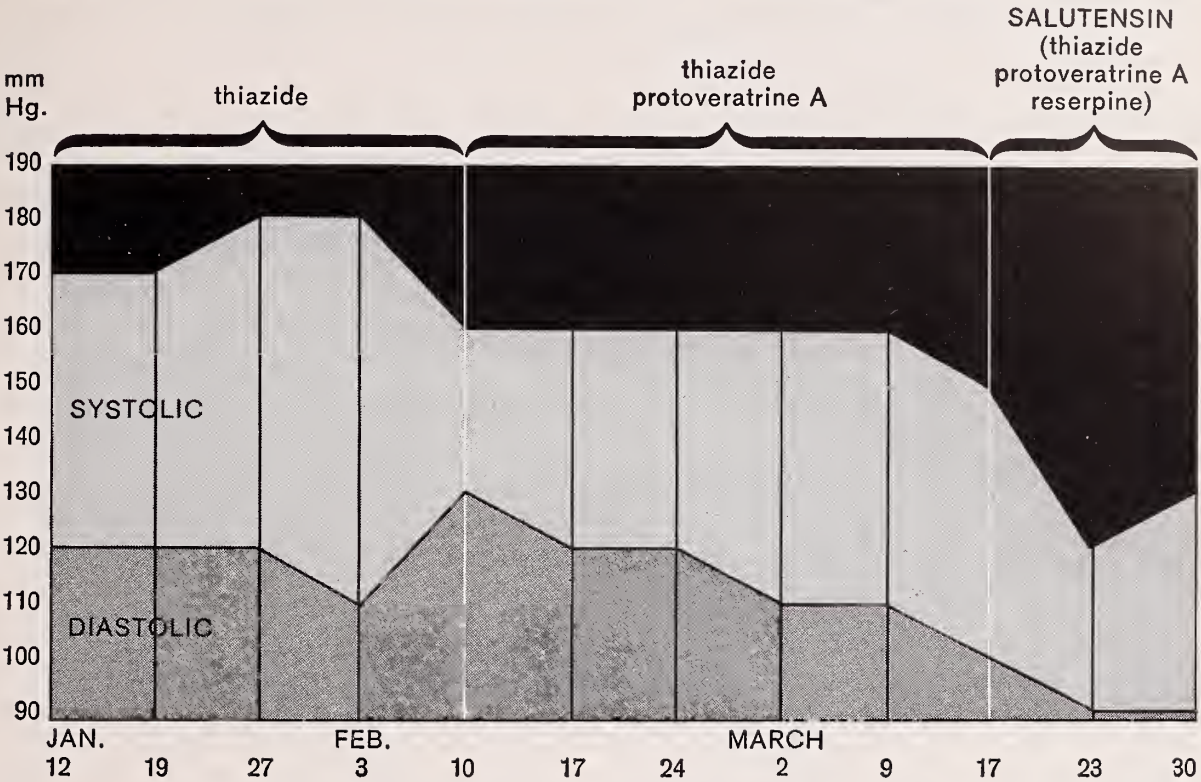
Supplied: Bottles of 60 scored tablets.

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all the antihypertensive benefits of thiazide-rauwolfia therapy plus the specific, physiologic vasodilation of protoveratrine A

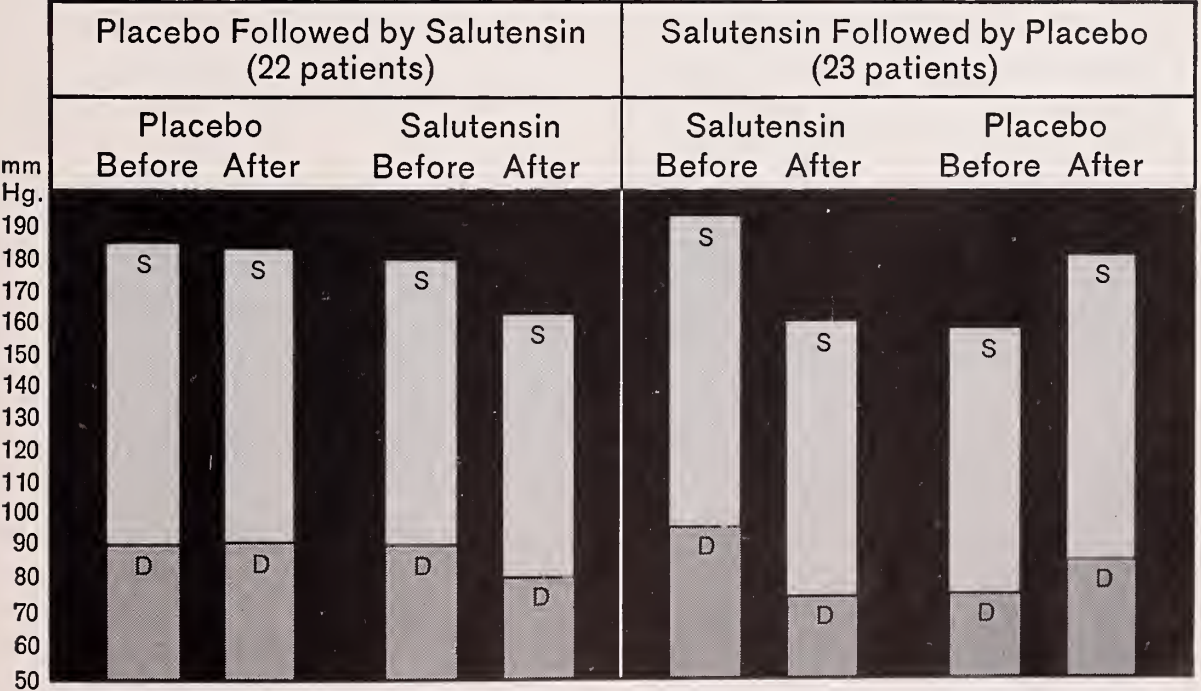
11 WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS BY SERIAL ADDITION OF THE INGREDIENTS IN SALUTENSIN IN A TEST CASE

(Adapted from Spiotta, E. J.: Report to Department of Clinical Investigation, Bristol Laboratories)



3½ WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS USING SALUTENSIN FROM THE START OF THERAPY IN A "DOUBLE BLIND" CROSSOVER STUDY

Mean Blood Pressures—Systolic (S) and Diastolic (D)



In this "double blind" crossover study of 45 patients, the mean systolic and diastolic blood pressures were essentially unchanged or rose during placebo administration, and decreased markedly during the 25 days of Salutensin therapy. (Smith, C. W.: Report to Department of Clinical Investigation, Bristol Laboratories.)



Georgia Medical Assistant to the Aged Act

GEORGIA'S NEW MEDICAL Assistance to the Aged Act, under the provision of the Federal Kerr-Mills law, became effective for *Old Age Assistance recipients* on January 1, 1962. So that physicians may become fully cognizant of their responsibility in the implementation of this program, we have printed the procedural data governing the operation of this Act entitled: "Medical Care Vendor Payment Program For Old Age Recipients Rules and Regulations Governing Hospital Care."

The State Department of Welfare is the sole agency responsible for the administration of this Act. However, the Department of Welfare has contracted with the Medical Association of Georgia for the Association to provide certain consultative services and medical determination in the processing of vendor claims from hospitals.

Under the present rules and regulations, only hospitals and nursing homes are entitled to submit vendor claims for patient care rendered to eligible OAA patients. Hospital care is limited to "*acutely ill or injured*" patients who cannot be adequately treated outside a hospital. As only physicians can certify that eligible OAA patients actually need such care, you are strongly urged to familiarize yourself with the enclosed directive governing this program.

Section I of the enclosed data titled, "Method For Approval of Participating Hospitals," is mainly the concern of the participating hospital.

Section II, "Method For Determining Patient's Eligibility," is also the concern of the hospital — but you as a practicing physician will undoubtedly be queried on eligibility by your patients *and you should know these regulations.*

Section III, "Criteria For Hospitalization," *is the direct concern of the Physician and must be studied in detail by every doctor.*

Section IV, "Hospital Claim For Services," *is also the direct concern of the physician,* because hospital claims for services must be filled out in part and signed by the attending physician before such claims can be processed by the Medical Association of Georgia.

Section V, "Medical Decisions And Appeals," concerns the validation of the hospital claim submitted for payment based on medical determination made by the Association to the Department of Welfare — *and as such should be understood by the physician.*

The Medical Association *does not participate* in the administration of the Nursing Home portion of the Medical Assistance to the Aged Act as this will be handled directly by the Department of Welfare. However, information data for patient admission to nursing homes is also printed.

We certainly wish to thank you for your cooperation in reading this material thoroughly — as we feel the success of this program in making provision for the improved health care of the aged is largely the responsibility of the attending physician.

John T. Mauldin, M.D., Secretary,
Medical Association of Georgia
Medical Director,
Medical Assistance to the
Aged Program

Alan Kemper, Director,
State Department of Welfare

Rules and Regulations Governing the Hospital Care Program for Old Age Assistance Recipients for the State of Georgia Effective January 1, 1962

Section I

Method for Approval of Participating Hospital

Section 1.1 Procedure for Becoming a Participating Hospital

1. Prerequisite to any hospital becoming a participating hospital under the Program, the governing authority of the hospital must elect to participate in the Program.
2. In expressing the desire of the hospital to participate in the Program, a responsible officer of the hospital shall complete a standard application form and shall submit such application to the Georgia Department of Public Welfare.
3. A hospital once approved will continue as a participating hospital until it voluntarily withdraws or its approval is revoked.

Section 1.2 Requirements for Becoming a Participating Hospital

1. To be eligible to participate in the Program, a hospital must have been issued a current licensure

permit under the laws of this state and must not be operated primarily for the care and treatment of tuberculosis, mental disorders, or other chronic diseases or illnesses. Only Georgia hospitals can participate in the Program except as may be hereafter provided under amendment to the rules and regulations.

2. To be eligible to participate in the Program, a hospital must be a general hospital providing major medical surgical services and/or acute short-term care.
3. To be eligible to participate in the Program, a hospital must maintain within the facility such standards as are hereinafter set forth:
 - (a) Have an organized governing body with rules and regulations;
 - (b) Continuous registered nursing service — nursing service under the supervision of registered graduate nurses, 24 hours a day, 7 days a week;
 - (c) Adequate medical records;
 - (d) Readily available diagnostic X-ray facilities;
 - (e) Laboratory facilities;
 - (f) Adequate diet kitchen;
 - (g) A medical staff with rules and regulations;
 - (h) At least six (6) beds for the care of non-related illnesses, the average stay of which is in excess of twenty-four (24) hours per admission;
 - (i) And be able to furnish cost data required in the filing of Georgia Hospital Cost Statement.
4. Any hospital accredited by the Joint Commission on Accreditation of Hospitals or The Georgia Hospital Medical Council will qualify as meeting minimum standards hereinbefore set forth under (a) through (i).
5. Any hospital not accredited by the above mentioned accreditation agencies shall complete a standard questionnaire form and shall submit such form to the Georgia Department of Public Welfare for use as a basis in determining eligibility for participation.
6. Any hospital electing to participate in the Program must agree to accept a calculated per diem related to the non-profit basic cost and must agree to submit a standard cost statement form to substantiate a "non-profit basic cost."
7. In the absence of a standard cost statement, any hospital electing to participate in the Program must agree to accept ten dollars (\$10.00) per patient-day of care pending submittal and approval of the required cost statement. No payment will be made under this rule for services rendered after June 30, 1962 to eligible hospitals not submitting a standard cost statement in accordance with current rules and regulations relative thereto.

Section 1.3 Certification as a Participating Hospital

1. Hospitals found eligible for participation in the Program shall be so certified by the Georgia Department of Public Welfare and the Department shall maintain a roster of hospitals participating in the Program and shall furnish a list of such hospitals to each County Welfare Department with changes as needed.

Section 1.4 Discontinuance as a Participating Hospital

1. A participating hospital has the right to withdraw from the Program at any time, after proper notice of this intent to the Georgia Department of Public Welfare, provided that the rights of patients are not jeopardized.
2. Should a participating hospital, at some future date, fail to comply with rules and regulations of the Program, the Georgia Department of Public Welfare shall remove the hospital from the roster of participating hospitals and shall advise the hospital concerned and the County Welfare Department that the hospital is no longer a participating hospital under the Program.

Section 1.5 Calculating the Per Diem Rate

1. The non-profit basic cost shall be determined from an analysis of the hospital's financial records and reports and all submitted cost statements must bear the certification of a registered public accountant who is not an employee of the hospital.
2. The Georgia Department of Public Welfare shall establish for each participating hospital an official per diem rate, which shall be an established percentage of the non-profit basic cost, or one hundred per cent (100%) of the non-profit basic cost, or one hundred per cent (100%) of the non-profit basic cost subject to a maximum, as determined by funds available. A tentative per diem rate will be negotiated in the case of a new hospital which does not have sufficient operating periods to establish a sound basic cost rate.
3. "Standard cost statement" hereinbefore referred to means Georgia Hospital Cost Statement with related rules and regulations now used for other medical care programs under the sponsorship of the State of Georgia. The Georgia Department of Public Welfare shall not require the submission of additional cost statements for this Program.
4. A participating hospital grants to the Georgia Department of Public Welfare, the Federal Department of Health, Education, and Welfare, and the Comptroller General of the United States the right to audit submitted cost statements and claim records against its financial records, and the right to inform county welfare departments of its per diem rate.
5. For any participating hospital, the official per diem rate shall not exceed the average computed cost per in-patient day based on private billing charges as reflected on Georgia Hospital Cost Statement.

Section 1.6 Hospital Services Included in the Per Diem Rate

1. The official per diem rate shall be an all-inclusive charge to cover all in-patient hospital care provided patients under this Program, ordinarily in rooms of three or more beds, but when medically indicated or when no other accommodations are available, in rooms with a lesser number of beds, including the use of operating rooms, all treatment, therapeutic and diagnostic services, drugs and medicines, casts and dressings, oxygen, plasma, and all other services rendered by individuals who receive remuneration (salary or con-

tractural basis) from the hospital for such services. There is no provision under the Program for paying of professional charges on a personal billing fee basis.

Section II

Method for Determining Patients Eligibility

Section 2.1 Persons Eligible for Hospital Care

1. Persons eligible for hospital care under the Program are recipients of Old Age Assistance.
2. An authorized Old Age Assistance recipient is eligible for a vendor payment for hospital care only in the months in which he is eligible for a money payment in Old Age Assistance.
3. This definition of persons eligible for hospital care does not include the spouse not eligible in his or her own right although included in the Old Age Assistance recipient's budget as an essential person.

Section 2.2 Eligibility in Relation to Number of Days Care

1. Each recipient of Old Age Assistance is eligible for a maximum of ten (10) days of hospital care per admission but limited to a total of thirty (30) days of hospital care per calendar year.
2. Days of hospital care not used by a recipient of Old Age Assistance in one calendar year shall not be carried over to the next year.

Section 2.3 Certification of Eligibility for Hospital Care

1. The Director of the County Welfare Department of the patient's county of residency shall, if appropriate, certify to the receipt of Old Age Assistance by the patient and shall approve ten (10) days of hospital care, or the number of remaining days of hospital care for which the recipient is eligible in the current year, or the number of days until Old Age Assistance is to be terminated or suspended, whichever number is the smallest; or explain why hospitalization must be denied.
2. The hospital must request certification of eligibility on a standard Admission Notice form consisting of two (2) copies of a five (5) part snapshot Statement of Hospital Services form. The Admission Notice copies of the form carry patient identifying information and signature only.

Section III

Criteria for Hospitalization

Section 3.1 Definition of Reimbursable Hospital Care

1. This Program shall provide essential hospitalization for the acutely ill or injured who have been certified as eligible for hospital care according to the eligibility criteria set forth in Section II of these Rules and Regulations.
2. The "acutely ill or injured" are defined as those otherwise eligible Old Age Assistance recipients with acute illnesses or major injuries which cannot be treated adequately outside a hospital. Acute illnesses or acute medical conditions shall include acute exacerbations or acute complica-

tions of chronic diseases, emergencies of any nature which are a threat to the life and health of the patient. The condition of "acutely ill or injured" must exist at time of admission to hospital and hospitalization must be essential to the treatment of the patient.

3. Hospitalization shall not be provided under this Program for a patient as a result of a diagnosis of tuberculosis, cancer or psychosis, except hospitalization for cancer or tuberculosis involving an acute emergency of lifesaving surgical treatment to permit adequate time for transfer to the appropriate medical care State program, with such transfer at the earliest possible time.
4. No person shall be eligible for hospitalization under this Program to the extent that he is otherwise eligible for treatment under any other program including the State Cancer Program, Veterans Administration, Vocational Rehabilitation, Workmen's Compensation, or through the legal obligation of a contractor, public or private, to pay or provide for his care.

Section 3.2 Other Conditions Relating to Hospital Care

1. It shall be the sole responsibility of the Old Age Assistance recipient's physician in consultation with the recipient to determine the participating hospital to which the recipient is to be admitted. For the present, only Georgia hospitals can participate in the program.
2. The hospital shall agree to complete necessary treatment and discharge the patient in the minimum number of days consistent with good medical care.
3. The recipient's attending physician must sign statement on the standard billing form that in his professional opinion the patient was acutely ill or injured at time of admission to hospital and that hospitalization was essential to the treatment of the patient.
4. The hospital form information furnished by the referring and/or attending physician must complete Section B—Medical Information on the standard billing form. Required information relates to admitting diagnosis; type of medical, surgical, or diagnostic procedure(s) rendered; and final primary diagnosis and secondary diagnosis, if any.

Section 3.3 Post Review of Medical Information

1. After discharge of the patient, the hospital shall submit claim for services through the Medical Association of Georgia for a post review of required medical information and determination that the illness or injury comes within the limitations of the Program for Old Age Assistance recipients and the vendor service contained in the claim is reasonable as related to the diagnosis. Payment of a claim for services is contingent upon approval by the Medical Association of Georgia for conformity with the medical aspects of the rules and regulations.

Section IV

Hospital Claim for Services

Section 4.1 Claim Form

1. The hospital's claim for services must be submitted on a properly completed Statement of Hospital Services, Form DPW 397 provided for this purpose.

Section 4.2 Calculating Amount Due Hospital

1. The hospital's claim for services must show date patient admitted to hospital, date of discharge, and total days in hospital. A day shall include the day the patient is admitted, but not the day he is discharged, except in the rare instances of one day admissions.
2. The hospital in determining the number of days for which the State assumes responsibility shall compare number of days certified by the County Welfare Department as the patient's maximum entitlement with the total days in the hospital, and use the lesser of the two figures times the official per diem rate in computing the total amount due hospital.
3. When a hospital's official per diem rate is changed, for any reason, the rate in effect on the date the patient is admitted to the hospital shall be used in computing the total amount due the hospital.

Section 4.3 Payment from Other Sources

1. Payment by the State to the hospital at the official per diem rate shall be considered full payment for all services rendered during the period of hospitalization for which the State assumes responsibility and the hospital shall accept no payment *in excess of the agreed rate* from the patient or other person for said period. Hospitalization insurance and other third party payments shall be considered as payment in part of the agreed rate and treated in accordance with Section 4.3 (2) below.
2. The hospital shall apply as a credit in determining the net claim for payment due from the State any hospitalization insurance or other third party payment *applicable to the period for which the State assumes responsibility*, said period to be construed as beginning on the date of admission. (See Section 4.4(4) for determining when "applicable to the period for which the State assumes responsibility".)
3. Should the hospital collect from the patient or his family any amount for services rendered during the period of hospitalization for which the State assumes responsibility, even though such payment may be for accommodations of a class better than that provided by the State, as defined in Section 1.6(1), the payment shall be applied as a deduction from the agreed rate in the same manner as provided for hospitalization insurance and other third party payments in Section 4.3(2) above.
4. The hospital shall be free to seek payment from appropriate sources for any days of hospital care required by the patient beyond the period of hospitalization for which the State assumes responsibility, except no payment shall be sought from personal funds of an Old Age Assistance recipient. The exclusion of personal funds of an Old Age Assistance recipient shall not apply to hospitalization insurance or other third party payment paid directly to the patient instead of the hospital.

Section 4.4 Deductions from Claim—Insurance, etc.

1. The hospital shall determine the amount of hospitalization insurance benefits available to the recipient and shall take into account such insurance and all other payments made to the hospital by a third party (when applicable to the period authorized for payment) in determining the net claim or payment due from the State, as stated in Section 4.3(2). The claim for services form has a line for the deduction of such collections from total amount due the hospital, on a due or received basis.
2. If a hospital receives unreported insurance or other third party funds for the period authorized for payment after the bill is paid, it shall be the responsibility of the hospital to reimburse the State Department of Public Welfare.
3. In the rare instances when insurance or other third party funds applicable to the period authorized for payment exceeds the per diem rate, the hospital may elect not to complete and file a statement of hospital services. In such instances, the approved admission notice must be returned to the certifying County Welfare Department with a letter of particulars, in order that days encumbered against the recipients days of entitlement because of the certification may be cancelled.
4. The hospital shall determine what portion of insurance and other third party funds are applicable to the period authorized for State payment in accordance with the following general rule. In insurance benefits, the stipulated daily amount for bed and board shall be applied at said rate beginning with the day of admission until exhausted, an allowance for extras shall be applied against appropriate charges beginning with the day of admission until exhausted. However, in cases of surgery, allowance for extras may be applied beginning with the day of surgery instead of day of admission. Where payment represents a lump sum hospitalization or injury settlement from an insurance company or other third party, without stipulation as to days of coverage, etc., the total payment shall be divided by the total days in hospital to arrive at a daily rate, then, multiply the rate thus obtained by the number of days in the period authorized for State payment to arrive at deductible amount to be shown on claim form.

Section 4.5 Submission of Claim Form

1. Completed claim form must be signed by the hospital's chief administrative officer and submitted, in duplicate, to the Medical Association of Georgia for post review of medical information. (See Section 3.3(1).)
2. Claim form will not be accepted unless accompanied by
 - (a) Copy of Admission Notice certified by the by the Director of the County Welfare Department of the patient's county of residency as to eligibility for hospital care and days of entitlement.
 - (b) A copy of the patient's itemized statement, carrying customary detail, by days, of accommodations and services with private patient charge rates; also, reflect credit entries of collections from all sources applicable to the

particular account. This statement of account must cover the total days of hospital care.

3. In order to keep a close check and accurate statistics on the cost of hospital care, hospitals are asked to submit claims for payment within ten (10) calendar days after the discharge of each payment, except in situations involving inability to determine the exact amount of a third party credit. A delay is preferable in such cases.
4. Any claim received more than ninety (90) days after the date of discharge will not be approved for payment.
5. The State Department of Public Welfare shall pay all approved claims directly to participating hospitals.

Section V

Medical Decisions and Appeals

Section 5.1 Source of Regulations on Medical Decisions and Appeals

1. Procedural regulations concerning contacts with physicians and hospitals relating to medical decisions and the right of appeal granted a recipient of Old Age Assistance and vendors furnishing services under the program are taken from Agreement on Hospital Care between the Georgia Department of Public Welfare and the Medical Association of Georgia.

Section 5.2 Medical Decisions

1. The State Department of Public Welfare shall utilize the services of The Medical Association of Georgia in making contacts with the hospitals and physicians relating to medical decisions and The Medical Association of Georgia shall make such contacts except where the exigencies of efficient and proper administration require direct contact by the State Department of Public Welfare. Where it is necessary for the State Department of Public Welfare to make direct contacts with hospitals and physicians relating to medical decisions, the State Department of Public Welfare shall endeavor to advise The Medical Association of Georgia in advance of any such direct contact. The Medical Association of Georgia shall keep the State Department of Public Welfare informed of problems encountered in discharging its duties under this program and will advise as to the need for policy changes.

Section 5.3 Appeal by a Recipient

1. In the administration of the hospital care program for Old Age Assistance recipients, any recipient who believes that he has not been given proper consideration shall have the opportunity for a fair hearing before the Director of the State Department of Public Welfare. The Medical Association of Georgia shall cooperate with the State Department of Public Welfare in obtaining the true facts from hospitals, physicians and related personnel in all cases where a recipient has requested a fair hearing in connection with the

hospital care program. The decision of the State Department of Public Welfare on the issues in question shall be binding.

Section 5.4 Appeal by a Hospital

1. In the administration of the medical aspects of the hospital care program for Old Age Assistance recipients, any vendor who feels that he has not been given fair and equitable treatment shall have the right to appeal to The Medical Association of Georgia. In the event the decision which he is appealing is sustained, he shall have the further right of appeal to the Director of the State Department of Public Welfare. The Director of the State Department of Public Welfare may, of his own motion, review, de novo, any appeal of an aggrieved vendor.

Nursing Care Home Vendor Payment Program for Old Age Assistance Recipients Informational Data on Patient Admission to Nursing Homes

Old Age Assistance recipients who are certified by a physician as actually needing nursing care in a licensed nursing home may receive a vendor payment in their behalf after January 1, 1962, if such care cannot be provided at home. This program is not designed to provide domiciliary care—it will aid only those Old Age Assistance recipients who require actual nursing care.

Only nursing care homes which hold a permit or license from the State Department of Public Health as (1) medical nursing care homes, (2) skilled nursing care homes and (3) nursing care homes are eligible to receive vendor payments. Personal care homes, although licensed by the Department of Public Health, are nonmedical and therefore not eligible to receive vendor payments under this program.

Maximum payments to nursing homes will vary according to the classification of the nursing home. A medical nursing care home may receive a maximum vendor payment of \$175, a skilled nursing care home \$150, and a nursing care home \$125. In determining the amount to be paid, charges made by the home to the general public and the recipient's ability to pay a part of the cost will be taken into consideration.

Information on the nursing care home vendor payment program in behalf of Old Age Assistance recipients is available from the county departments of public welfare. The county departments of public welfare will forward to the doctor, Physician's Recommendation Regarding Nursing Home Care, Form DPW 185, along with a self-addressed, stamped envelope, to be filled out in duplicate on each Old Age Assistance recipient applying for nursing care home vendor payment. The Department of Public Welfare has no provision for paying the physician for this statement.

Physicians attending recipients of Old Age Assistance who are in need of nursing home care should contact the county department of public welfare for information on participating licensed nursing care homes in order that they may know the facilities available under this program.

SUPPORT FOR KERR-MILLS PROGRAM URGED

FRED H. SIMONTON, M.D.

WITH THE BEGINNING of the New Year it seems appropriate that your President devote this column to the beginning of a new program.

As discussed in detail elsewhere in this issue of the JMAG, Georgia's Medical Assistance for the Aged Act became operational on January 1, 1962.

The launching of this Act, popularly known as the Kerr-Mills Program, followed many months of arduous and painstaking preparation by MAG, the Georgia General Assembly and the Georgia Department of Public Welfare.

As I'm sure all of you know, the Medical Association of Georgia has, by contract, become a partner in the administration of this program, together with the State Welfare Department. Together we have embarked on a new era in medical, hospital and nursing home care for our indigent older citizens. All of those who have worked so diligently to perfect this plan deserve not only our commendation, but our wholehearted support as well. Indeed, if the program is to succeed, as we all know it can, a sincere, dedicated effort by all physicians, hospitals and nursing homes will be required.

The enactment and implementation of the Kerr-Mills program is what we have all been working toward for a good long time. This will perhaps be our best chance ever to help eliminate fear and doubt in the minds of some of our older citizens regarding their health needs. It will likewise demonstrate to a world being fed an unbalanced political diet that the medical profession is not content to merely talk about the problem facing some of our senior citizens, but rather has shown an inordinate determination to solve the problem.

Overcoming inertia is step one to the solution of any problem. The implementation of the Kerr-Mills program has moved the matter off dead center and started the ball rolling in the right direction. However, this is only a part of the job. The true test of

the ability of the Kerr-Mills program to solve the problem lies not in its beginning or its presence on the statute books. Rather, the effectiveness of this program will be found in the dedication with which the state's physicians and all others concerned apply themselves to the day-to-day operation of this program.

Maximum cooperation by each of us on every aspect of the program is a must. Anything less will surely impede its perfection and seriously jeopardize its progress.

I earnestly solicit every member of MAG to cooperate to the fullest to make this program a success worthy of duplication by the remaining 49 states of the Union.

In a recent issue of a publication entitled "The Right Hand" the following squib appeared: Character is not a single quality but a three dimensional achievement built on the foundations of decision, direction and dedication. Decision and direction are much in evidence. Without them there would be no Kerr-Mills program wherein the state and the free practice of medicine could join hands to administer an aid project felt by some to be the sole province of the Federal Government. What we need now is great abundance to complete the ring of character and dedication. Dedication to the success of the Kerr-Mills program, dedication to its fair and equitable administration, and dedication to the concept that it can do the job of providing medical, hospital and nursing home care for all those who cannot help themselves.



President, Medical Association of Georgia



LIABILITY OF CHARITABLE HOSPITALS

John L. Moore, Jr.

A QUESTION OFTEN asked by physicians is whether hospitals can be liable for the negligent injury of patients. It is entirely clear that a proprietary hospital operated for profit is fully liable just as any other business incorporated for profit. The answer as to charitable hospitals is more complex.

By "charitable" is meant any nonprofit corporation. It does not matter whether funds are supplied by contributions or from tax funds. The hospital is still charitable if its purpose is nonprofit even though it may also have income from pay patients.

Early decisions in England and the United States rather carefully protected charitable corporations from liability for negligent acts of its employees. At first, the courts relied on a "trust fund" theory. They said that a charitable corporation was organized for the purpose of rendering services to humanity and not for the purpose of paying judgments. Consequently, they refused to make such corporations liable for negligent acts of employees. However, this position was so extreme that courts began to question it and to find reasons for not following it.

In Georgia, the definitive decision was handed down by the Supreme Court in 1918, in a case involving the Savannah Hospital. In that case the Supreme Court allowed a pay patient in the Hospital to recover for his negligent injury by an employee of the Hospital. However, the Court only allowed him to collect from the noncharitable funds of the Hospital, that is, from the funds derived from payments by pay patients. The Court went on to say that he could not recover from the charitable trust fund of the Hospital unless he showed that the corporation itself, by its officers, had been negligent in employing the negligent employee.

Another doctrine developed by courts to protect charitable corporations from liability is the "implied waiver" theory. That theory says that a charitable, nonpay patient waives his normal rights to recover from the corporation for the negligent acts of its agents. There is an exception to this rule if the corporation itself failed to exercise reasonable care in the selection of the employee who injured him. This theory is also recognized in Georgia and adds to the complexity of answering inquiries on the subject.

The situation in Georgia at the present time can be summarized as follows:

1. A charitable hospital does not enjoy absolute immunity from liability for negligent injury.

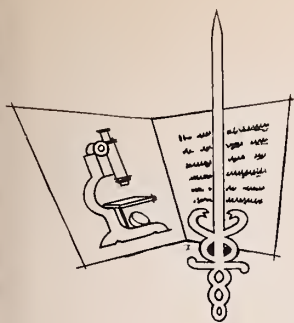
2. A charitable hospital which takes pay patients is in the same position as any other private corporation with respect to its activities relative to the non-charitable patients. However, it is not so liable to charitable patients unless the officers of the corporation were negligent in selecting the employee.

3. Recovery from a charitable hospital is generally restricted to the funds derived from pay patients. Recovery may usually not be had against those funds received from contributions or tax sources.

In most cases which arise the above rules mean that a plaintiff needs to be careful in his allegations and proof. However, in most cases he will be able to recover just as he would against a for profit corporation. Any trend to be observed is in favor of extending the liability of hospitals.

For these reasons, a hospital should generally assume that it will be liable like other corporations. It then may be able to find an exception from this general rule to protect it.

Prepared at the request of the Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Sibley, Miller, Spann, and Shackelford, general counsel for the M.A.G.



WHAT PRICE CANCER CARE

John Barner, M.D., *Athens*

IN 1937 PUBLIC Act No. 473, known as the Indigent Cancer Program was passed by the General Assembly and since this time there has been a steady growth of the cancer services, until today there is a financial burden of properly and thoroughly maintaining the program.

Originally the program was financed with \$50,000 annually from moneys appropriated to the Department of Public Health. Today about \$400,000 is set aside each year to carry this program, and more is needed.

In the very beginning there were five clinics in Georgia, all approved for cancer treatment by the American College of Surgeons. Today there are 20 such approved clinics strategically situated throughout the State. During the first full year of operation, 1388 patients were referred to the clinics and, of these, 935 were found to have cancer of one type or another. At the present time there are, on an average, about 1800 new cancer cases a year, but the various clinics are caring for an average of 4000 old and new patients a year.

Since 1937, when the program was started, great strides have been made in cancer care. Not only are more cancer cases being diagnosed, but the types of cancer are more varied. Treatment, both surgical and radiation is more extensive and intensive. The introduction of the antibiotics and newer anaesthesias have extended the types of surgical procedures and have allowed a more radical approach in many of these procedures. The better understanding of radiation and radio-active substances permit a higher and more thorough type of treatment. The recent cancerogenic drugs open even a new approach.

To carry out these accepted treatments, indigent or private patients require longer hospital stays, intensive nursing care, expensive medications, and more professional attention.

What is the solution? If and when the programs for Indigent care become a reality some of the problems of cancer care may be solved. The OAA,

MAA, Kerr-Mills, even the HIC plans are not the absolute answers. Cancer care goes deeper than a socialized approach to handling most illnesses and infirmities. Cancer, today, is the second greatest killer and attacks all ages, all races, and all economic levels. We must maintain our clinics and assume control of the clinics under the original 'Cancer Prevention and Cure' act.

This should be no time to limit care to the indigent cancer case, if anything this care probably should be extended. The public, as well as the physician, has come to recognize the cancer clinic as a center where not only indigent patients are properly treated, but often where their private patients can be referred, not on State aid. Many would like to see these clinics care for all kinds of tumors, benign as well as malignant, and the associated or allied diseases of cancer, but as the regulations are today specifically only cancer cases may be treated.

The public closely associates these clinics with the American Cancer Society's work because the Society sponsored the legislation in 1936 setting up the State Aid Cancer Control program and gave financial aid to the clinics to help them get started. The Society provided clinics partial funds for equipment; at one time it gave each clinic funds for clerical aid and in the past three years has spent over \$92,000 on the Tumor Registry Program since a registry is now required for approval by the College of Surgeons. The Society does *not* pay for treatment. Its main objective is public and professional education to cause earlier detection which means better likelihood of cure.

Last year the Society aided 2,573 indigent cancer patients, most of them from these clinics, with such things as pain relieving drugs, transportation to the clinics, visiting nurse service, the loan of hospital beds, dressings and sick room conveniences.

We should all, as physicians, recognize the place these State Aid Clinics have in our medical care program, assist the clinics, and improve their relationship with the public.

Every effort should be made to have the appropriations for operation of these clinics raised to compensate for the increasing number of indigent cancer cases and the rising cost of indigent care. Georgia has

Approved by Professional Education Committee, Georgia Division, ASC.

MATERNAL AND PERINATAL STUDY PROGRAM BEGUN

THE PERINATAL MORTALITY GROUP of the Subcommittee on Maternal and Infant Mortality of the Medical Association of Georgia will begin, on January 1, 1962, an extensive review of fatal and neonatal (perinatal) deaths throughout the state. The initial phase of the study will be concerned with stillborns and live-born infants dying neonatally who weigh between two pounds one ounce and five pounds eight ounces (1000-2500 grams) at birth. Approximately one-tenth of the cases in this category will be selected for detailed analysis. Unfortunately, death certificates will not provide sufficient information to aid the committee in this study, hence it will be necessary to ask the physician or physicians who participated in the case under review to furnish additional information to this committee. The questionnaire form, which will be mailed to the physician for completion, has been carefully chosen to provide the data which the committee will need to carry out a meaningful study. The following explanatory letter will accompany the form:

Dear Doctor:

The Maternal and Infant Welfare Committee of the Medical Association of Georgia is carrying out an extensive and detailed study of maternal and perinatal deaths occurring in the State.

This work is being done in order to determine the cause or causes of these mortalities, and to find ways of reducing the incidence of avoidable deaths. It is, therefore, important that we obtain

entertained the position of being one of the States leading in Cancer education and treatment and should be kept as a leader.

The various clinics throughout the state serve all counties, and therefore it is obvious that they are a State responsibility and not a liability of the county in which the clinic is located.

the full support and cooperation of all Georgia physicians in completing and returning the questionnaire forms sent them regarding perinatal deaths which are to be reviewed. For the purposes of research, the bare diagnosis on the death certificate is inadequate. May we, therefore, ask your cooperation in supplying additional information on the case attached to this letter? As you will observe, the questionnaire is to be identified only by a code number. When the material is reviewed by the Maternal and Infant Welfare Committee, no other identification will be used. The Committee is composed of physicians who are familiar with the practical problems involved. In reviewing current neonatal mortalities, they will be concerned, not with destructive criticism, but with the analysis of cause and effect, and with recommendation of improved methods of management. The Committee will be glad to send you the comments on this particular case.

We believe our fellow physicians share our objective which is to improve the production of normal human beings. We are counting strongly on their support in this undertaking—the success of this, and any subsequent, study will be in direct proportion to their help and cooperation.

*William E. Laupus, M. D.
Chairman
Perinatal Mortality Group*

TREATMENT OF DIABETES

Because of its prevalence and chronicity, diabetes mellitus should be the continuing concern of all physicians, regardless of their type of practice. An essential part of treating the condition is teaching the patient how to live with it.

As in any educational program, a systematic approach should be used. Each physician should have certain specific objectives clearly in mind as he teaches his diabetic patients.

To aid him, the American Diabetes Association has prepared the following check list of nine basic elements of treatment, which constitutes a minimum program for diabetes management. There are many other aspects of treatment which are not mentioned, but they

are not as important as are the following:

1. Diet
2. Urine testing
3. Action of insulin and other hypoglycemic agents
4. Technique of insulin injection and sites for it
5. Care of syringe and of insulin
6. Symptoms of hypoglycemia
7. Symptoms of uncontrolled diabetes
8. Care of the feet
9. What to do in case of acute complications

This guide is not only of value in the initial education of a new diabetic, but can also be most helpful to both patient and physician in the subsequent years of management.



SIDE EFFECTS OF HYPERTENSIVE TREATMENT

Frank Wilson, M.D., *Leslie*

UNFORTUNATELY DRUGS administered in the treatment of disease do not have just the effects desired, nor does everyone respond alike to a given drug or regimen. These are particularly true in the treatment of hypertension. We must always be alert to prevent or recognize and correct undesirable reactions to treatment.

First, because of associated arterial or renal disease, sudden lowering of blood pressure may produce serious complications regardless of the agent used. These are particularly prone to occur in the aged or those with extensive atherosclerosis. The initiation of therapy should be extremely cautious if patient is known to have cerebral or coronary arterial insufficiency. The onset of cerebral symptoms, either localized or general as disorientation, wooziness, vertigo, etc. should demand withdrawal of medication. Similarly, the onset of or increase in anginal pain should be watched for. The old saying of "blood pressure high enough to have a stroke" is misleading. Some of these people require this pressure to maintain cerebral circulation. Nephrosclerosis with renal failure is most frequently made worse by lowering pressure and if the B. U. N. is over 100, the situation is usually hopeless. With the use of very low sodium diets, the low sodium syndrome characterized by weakness, nausea, vomiting and collapse occurs but rarely except in patients with severe renal disease.

Rauwolfia or its derivatives are widely used anti-hypertensives but may have deceptive and serious side effects. The most severe of these is severe depression which can lead to suicide. This is common with large doses but may occur with usual dosage. Depression may be preceded by lethargy, loss of ambition, disturbed sleep pattern and often loss of initiative to report symptoms to the doctor, occasionally requires shock therapy but usually clears after stopping the drug. These drugs should never be used in the already depressed patient. Nightmares of a violent nature may occur. G. I. bleeding either from

increased excretion of HCl with aggravation of an ulcer or from as yet unexplained sources may occur. Of less importance are bradycardia, nasal stuffiness which may lead to sinusitis and otitis, increased G. I. tract motility with diarrhea and impotence in males. There is sometimes an increase in the appetite associated with excessive weight gain. Occasionally paralysis agitans may occur as with other tranquilizers. These drugs have an almost flat dose response and should be used in doses not to exceed reserpine one mg. per day. Add another drug—do not increase reserpine.

Hydralazine (Apresoline) is a useful drug which has fallen into little use because of the disturbing acute side effects. Severe headache, tachycardia, palpitation, dyspnea on exertion, nausea, vomiting, aggravation or production of angina which is not always proportional to drop in blood pressure are all disturbing symptoms. These can almost always be prevented by the preceding or concomitant administration of other anti-hypertensive drugs as rauwolfia, chlorothiazide or ganglion blocking agents and the beginning with a small dose of 25 mg. per day or less and gradually increasing. Following prolonged administration and large doses, usually greater than 400 mg. per day, a syndrome with the characteristics of lupus erythematosus may occur. This disappears with discontinuance of the drug but occasionally requires ACTH or steroid therapy. When fully developed includes arthritis, rash, fever, anemia, hematuria, lymphadenopathy and splenomegaly, albuminuria and even L. E. cells. Apresoline rarely has caused acute psychotic reaction.

The ganglion blocking agents produce symptoms relative to the interference with cholinergic nerve transmission. Orthostatic hypotension and compensatory tachycardia with fainting are relieved by lying flat. Interference with response to stress and the loss of adrenalin reaction in hypoglycemia must be watched for. Blurred vision, intolerance to bright light, dryness of mouth, loss of potency are less

serious. Urinary retention is a dangerous complication. Constipation from lessened intestinal motility must be avoided because of the danger of massive absorption and paralytic ileus. Saline laxatives should be used daily and the drug withheld if no stool. The bowel remains responsive to prostigmin. Guanethidine (Ismelin) is the most potent and least toxic of this group. It has long duration of action and cumulative effect. When orthostatic hypotension and fainting occur, the dosage must be omitted for several days and then schedule started over again. Increases in dose should be no more often than five to seven days. Diarrhea and bradycardia are signs of over dosage and may be controlled by atropine.

The thiazide group of drugs remove sodium and may with decreased salt intake or renal damage result in hyponatremia. More often there is depletion of body potassium. These effects are most dangerous

in critically ill patients and those not taking adequate fluids and food by mouth. The amount of potassium in many of the combination tablets is not adequate to replace loss. The precipitation of gout is a not uncommon occurrence and should be considered with the onset of joint symptoms. Other rare side effects are skin rash, bone marrow depression and diabetes mellitus.

The Veratrum alkaloids have a narrow range between therapeutic and toxic doses. Symptoms include epigastric and substernal oppression, nausea, vomiting, sweating and marked hypotension, bradycardia and disturbances in cardiac conduction or rhythm. Atropine counteracts Vagal phenomena and ephedrine or other vasoconstrictors the hypotension. These may have usefulness for acute control of hypertension. However, long term regulation is difficult.

By the careful selection of the drugs and judicious combinations of two or more agents, many of the undesirable effects may be avoided.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

MAG SCHEDULES ANNUAL OFFICERS CONFERENCE

Attention all County Medical Society Officers. If you have not already put a red circle around February 17th on your 1962 calendar, now is the time to do so. Don't delay, but make your plans now to attend the Fourth Annual County Medical Society Officers Conference in Atlanta.

This annual event, scheduled to begin at 1:30 p.m. on Saturday, February 17th at the Dinkler-Plaza Hotel will present an impressive array of medical and lay speakers. A wide variety of subject matter all designed to assist you in leading your county medical society, will complement a tightly organized program.

The Honorable Bruce Alger, Member of Congress from Dallas, Texas, will be the lead off speaker following the opening formalities of the Conference.

Congressman Alger is a noted speaker with a message of vital importance to everyone who holds a leadership position in organized medicine. In addition to being a member of the powerful Ways and Means Committee of the House of Representatives, he is a devoted friend of the medical profession. Mr. Alger will discuss the importance of the medical profession having an eloquent and effective public voice and the necessity of such voice being heard.

A unique question and answer period tailored to effectively demonstrate the "how" in answering the questions received most frequently by the medical profession from the public will be presented during the Saturday afternoon session of this conference.

In addition to this, most of the top MAG officers will be on hand to explain many of the interesting and im-

portant facets of the operation of a medical organization. Included among these topics will be administrative responsibilities, state and national legislation, medical economics, and handling the actions and work of your County Medical Society.

A highlight of the Conference will be a detailed presentation of the rules and regulations governing the operation of Georgia's Medical Assistance (Kerr-Mills) to the Aged Act which went into operation on January 1, 1962. An additional special feature will be a short course on how to become a more effective public speaker.

This Conference is open to all county society officers and all are urged to attend. In addition, all county society chairmen of Public Relations Committees and others as the individual societies may direct are invited to be present.

The principle purpose of this Conference is to instruct and inform leaders of County Medical Societies in the best and most expeditious methods with which to lead their county medical organizations. At the same time it gives those who carry the burden of leadership in the County Societies an opportunity, on a person-to-person basis to "talk back" to the parent Association with a view toward improving the overall operation of organized medicine in Georgia.

This Fourth Annual Conference has been scheduled to dovetail with the opening of the Atlanta Graduate Medical Assembly which begins at noon on Sunday the 18th of February. We hope this will be added incentive for all county society officers to attend both meetings.



BOOKS RECEIVED

Wolstenholme, G. E. W. and Cameron, Margaret P., CIBA FOUNDATION STUDY GROUP 9, PROGESTERONE AND THE DEFENCE MECHANISM OF PREGNANCY, Little, Brown and Company, Boston, 108 pp.

Wolstenholme, G. E. W., and O'Connor. Maeve, CIBA FOUNDATION STUDY GROUP 10, BIOLOGICAL ACTIVITY OF THE LEUCOCYTE, Little, Brown and Company, Boston, 120 pp.

Runes, Dagobert D., THE ART OF THINKING, Philosophical Library, Inc., New York City, 1961, 90 pp., \$2.75.

Gelfand, Michael, MEDICINE IN TROPICAL AFRICA, A REALISTIC APPROACH, The Williams & Wilkins Co., Baltimore, 1961, \$7.00, pp. 243.

Ed. Brest, Albert N., M.D. and Moyer, John H., M.D., HYPERTENSION, RECENT ADVANCES, Lea & Febiger, Philadelphia 1961, 660 pp.

Donaldson, Blake F., M.D., STRONG MEDICINE, Doubleday & Company, Garden City, N.Y., 1962, 245 pp., \$3.95.

Glenn, Frank, M.D., ED. Wantz, George E., Jr. M.D. PROBLEMS IN SURGERY, The C. V. Mosby Co., St. Louis, 1961, 512 pp., \$16.50.

Carter, Richard, THE DOCTOR BUSINESS, Dolphin Books, Doubleday & Co., Garden City, N.Y., 1961, 276 pp., \$9.5.

Corday, Eliot, M.D. and Irving, David W., M.D., DISTURBANCES OF HEART RATE, RHYTHM AND CONDUCTION, W. B. Saunders Co., Philadelphia, 1961, 357 pp., \$8.50.

Gregory, Ian, M.D., PSYCHIATRY, BIOLOGICAL AND SOCIAL, W. B. Saunders Co., Philadelphia, 1961, 557 pp., \$10.00.

Tenney, Benjamin, M.D., Little, Brian, M.D. CLINICAL OBSTETRICS, W. B. Saunders Co., Philadelphia, 1961, 440 pp., \$8.50.

REVIEWS

Bard, Philip, Ed., MEDICAL PHYSIOLOGY, The C. V. Mosby Company, St. Louis, 1961, pp. 1339, \$16.50.

THIS BOOK ought to be of most use to medical students, medical investigators and those engaged in the practice of internal medicine. It has been written by a group of physiologists drawn primarily from The Johns Hopkins University, Columbia University and Harvard Medical School. They present the material in terms of experimental research upon which our present state of medical knowledge is based.

The book is clearly and well written; a small number of typographical errors are noted. Each chapter has adequate references; a detailed index makes topics easy to find throughout the book. The large number of illustrations are helpful for quick and easy comprehension of the written material.

This book ought to serve adequately as a modern reference book for the practicing physician or medical investigator; it should be helpful to the medical student in his didactic work in physiology.

C. B. Upshaw, Jr., M.D.

Dripps, Rogert D., Eckenhoff, James E.; Vandam, Leroy D., INTRODUCTION TO ANESTHESIA, W. B. Saunders, Philadelphia, 1961, \$8.00.

THE FIRST EDITION of this volume was published in 1957, and this publication represents a revision of the first edition. The subjects and the manner of their presentation represent the thinking and ultimate distillation into teaching practice of the senior anesthesiology staff at the University of Pennsylvania. The volume is well organized into chapters, each dealing with fundamental aspects of certain techniques and basic considerations of the drugs used in anesthesia.

Although certain specialized aspects of anesthesia, such as, hypothermia, deliberate hypotension, hypnosis, etc., were omitted from the first edition, these are included in this volume. In addition to these special techniques, there is also a discussion of intravenous therapy, asepsis in anesthesia, respiratory resuscitation, mechanical ventilation, pulmonary function and some of the medico-legal aspects or anesthesiology.

This book lends itself to easy reading and would be a definite addition to the library of anyone, be he anesthesiologist, surgeon, medical student, or in anywise involved in the management of patients undergoing surgery.

Each chapter offers sufficient references to those interested in pursuing these subjects further as an immediate reference source to the latest discussions of the various phases of anesthesiology.

Lester Rumble, Jr., M.D.

Adriani, John, M.D. ANESTHESIOLOGY, The C. V. Mosby Co., St. Louis, 1961, pp. 279 \$7.75.

WITH THE EVER increasing volume of clinical and experimental data appearing in the scientific journals, the task of keeping abreast of current trends has become almost impossible. Such a volume as has been prepared by Dr. Adriani and his co-authors is a worthwhile addition, especially to those with an active clinical practice. This book fills to a great extent an important void that has existed between the "old", as is found in textbooks, and the "new" as is represented in the current literature.

The book is divided into forty-five concise chapters, each being followed by its own selected references. The chapters vary from subjects that have been discussed for years such as "Shock and Anesthesia" and "Treatment of Shock," to the newer drugs, techniques and devices such as "Extracorporeal Circulation. Types of Pumps and General Uses." "Methods of Monitoring" and "Flurinated Compounds in Anesthesia," etc. In the words of the author, "these presentations are not intended to be exhaustive reviews," still enough material is included to stimulate the interest of all.

The great volume of current articles contains many of dubious value. It, therefore, has become necessary

PHYSICIAN'S BOOKSHELF / Continued

for men of Dr. Adriani's experience, ability and foresight to sift this maze of material for those of us who are not so richly endowed. This has been accomplished to a great extent in this book which makes it a most welcomed addition in the field of Anesthesiology.

A. J. Waters, M.D.

MAYO CLINIC DIET MANUAL, third edition, W. B. Saunders Co., Philadelphia, 1961, pp. 222, \$5.50.

THIS BOOKLET contains a clearly presented collection of dietary procedures in use at the Mayo Clinic and associated hospitals. The old stand-by diets are well-represented. In recognition of the importance of food in current diagnostic and therapeutic practice, several additional diets are included. Appropriate consideration is given diets modified for cardiorenal-vascular diseases with various combinations of lipid, protein and sodium content for both adults and children. The gluten restricted diet important in management of sprue and celiac disease is a welcomed addition. A reasonable discussion is devoted to the modified protein diets in liver disease.

Test diets for hypercalciuria include a 700 milligram calcium diet as well as a 120 milligram calcium test diet. A test diet for steatorrhea and azotorrhea is presented, but it is predicated on three day stool collections and quantitative analysis.

In the appendix are a number of interesting tables and charts which have been brought up to date. In addition there is a food nomogram for estimating caloric requirements under basal conditions. The rather broad range of dietary procedures and the presentation therein should provide physicians, dietitians and nurses useful information.

David E. Hein, M.D.

Fluhmann, C. Frederic, M.D., THE CERVIX UTERI AND ITS DISEASES, W. B. Saunders Co., 1961, pp. 556.

THIS BEAUTIFULLY and concisely written book is a storehouse of information on the diagnosis and treatment of the diseases of the cervix. It is the most complete and informative work yet written on the subject and should be a part of the library of every gynecologist and obstetrician. Radiologists and pathologists should also find it of great value.

The book has numerous illustrations and excellent photomicrographs to augment the reading material. The anatomy, histology and physiology of the normal cervix is fully discussed in the opening chapters of the book. This presentation gives an excellent background for the better understanding of the following chapters on abnormalities and diseases of the organ.

The discussions of useful diagnostic procedures such as cystological examinations, cone biopsy, Schiller test, analyses of secretions, and X-ray are quite informative. The technics for these procedures are covered in detail.

Diagnostic and treatment of all the benign and malignant conditions of the cervix are discussed. One section of the book is devoted to dysplasia, carcinoma in situ, preclinical invasion, and the relationship of these entities to invasive carcinoma. The methods of treatment of invasive carcinoma are completely covered.

The advantages and disadvantages of radiotherapy as opposed to the surgical approach are considered and the technics of each method are included. In the section on radiotherapy an excellent discussion of radioisotopes is given.

The obstetrician will be most interested in the chapters on the cervical complications and injuries of pregnancy and labor as well as in the section on the incompetent cervix. The final pages of the book are devoted to the management of carcinoma of the cervix in pregnancy.

This is the only volume to my knowledge which has been devoted entirely to the cervix. It is so complete in its scope that in the light of our present knowledge it leaves little else to be said about this important organ.

William C. Helms, M.D.

Krants, John C., Jr. and Carr, C. Jelev, PHARMACOLOGICAL PRINCIPLES OF MEDICAL PRACTICE, The William Wilkins Company, Baltimore, Md., 1961, pp. 1498, \$15.00.

THE LATEST EDITION of this popular work contains over 100 new drugs not mentioned in the 4th edition and is thus in line with the 16th United States Pharmacopeia and the 11th National Formulary. It contains an astonishing amount of information in its nine sections, 60 chapters and nearly 1500 pages. Controversial material has necessarily been reduced to a minimum but the concepts presented seem entirely sound. Critical workers in special areas, pharmacologists in particular, will doubtless find areas of disagreement without much difficulty but the clinician who wishes to use drugs wisely can rely upon the book with confidence. It is pleasant to see subjects presented against their historical background, and selected references appear at the end of each chapter. It is hard to imagine how a better job might have been done in one volume.

Thomas Findley, M.D.

PROCEEDINGS THIRTEENTH INTERNATIONAL CONGRESS ON OCCUPATIONAL HEALTH, Book Craftsmen Associates, Inc., New York, 1961, 1005 pp.

IN JULY 1960, the Thirteenth International Congress of Occupational Health heard some 258 papers covering an amazing variety of approaches to health problems that concerned the worker. Sociologists, Psychiatrists, Chemists, Physicists, and even a few Physicians discussed almost everything from head to foot, floor to ceiling. The wide scope and detail of these papers is most impressive.

Nevertheless, it is difficult to justify this volume. It is an example of a disturbing trend in the field of medical and other scientific publishings these days which is to assemble the papers presented at some national or international meeting and publish a large volume of proceedings. Whether this serves a really useful purpose is doubtful. Unless published elsewhere as well, the worthwhile papers are doomed to early obscurity by their limited circulation and by the flood of "fillers" and repetitious works which dilute the quality of the volume. There is not even an index in this work to allow the reader to look up some point of interest.

If its purpose is to demonstrate the scope of activity in the field of occupational health, a much less voluminous collection of abstracts would serve as well.

Thomas Sellars, M.D.

1962 CALENDAR OF MEETINGS

State

- Feb. 13-15—Cardiac Emergencies, Medical College of Georgia, Augusta, 18 hrs. Cat. I.
- Feb. 18-21—Atlanta Graduate Medical Assembly, Atlanta Biltmore Hotel, Atlanta, Georgia.**
- Mar. 20-22—Pre and Postoperative Care, Medical College of Georgia, Augusta, 18 hrs. Cat. I.
- April 2-4—Augusta Postgraduate Medical Assembly (Coincides with practice rounds of the Masters Golf Tournament) Augusta.
- May 6-9—Annual Session, Medical Association of Georgia.**

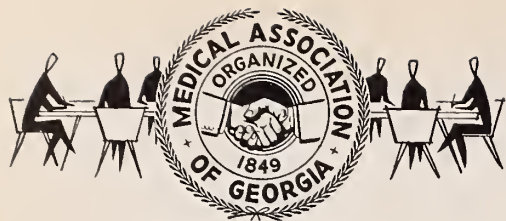
Regional

- Mar. 5-8—Southeastern Surgical Congress, Louisville, Ky.
- Mar. 12-15—New Orleans Graduate Medical Assembly, The Roosevelt Hotel, New Orleans.
- Mar. 18-21—Missouri State Medical Association, St. Louis.
- Mar. 26-28—American College of Surgeons, Sectional Meeting, Hotel Peabody, Memphis, Tenn.
- April 8-11—Tennessee State Medical Association, Peabody Hotel, Memphis, Tenn.
- April 23-25—Annual Meeting West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, West Virginia.
- April 26-28—Alabama, Medical Association of the State of, Tutwiler Hotel, Birmingham, Ala.
- April 29-May 2—Arkansas Medical Society, Arlington Hotel, Hot Springs, Ark.
- May 5-9—Medical Society of North Carolina 108th Annual Meeting, Sir Walter Hotel, Raleigh.
- May 7-9—Louisiana State Medical Society, Hotel Frances, Monroe, La.
- May 8-10—Mississippi State Medical Association, Hotel Heidelberg, Jackson, Miss.
- May 8-10—South Carolina Medical Association, Ocean Forest Hotel, Myrtle Beach, S. C.
- May 9-13—Florida Medical Association, Americana Hotel, Miami Beach, Bal Harbour.
- May 12-15—Texas Medical Association, Austin, Tex.

National

- Feb. 3-6—Congress on Medical Education and Licensure, Palmer House, Chicago.

- Feb. 5-7—American Academy of Allergy, Denver-Hilton Hotel, Denver, Colorado.
- Feb. 7-9—American Academy of Occupational Medicine, Pittsburgh-Hilton Hotel, Pittsburgh, Pa.
- Feb. 7-10—American College of Radiology, Roosevelt Hotel, New York, New York.
- Feb. 8-10—Society of University Surgeons, Cleveland, Ohio.
- Mar. 20-23—American Association of Anatomists, Minneapolis, Minn.
- March 21-24—Neurosurgical Society of America, Buena Vista Hotel, Biloxi, Mississippi.
- March 30-April 1—American Society for the Study of Sterility, The Drake Hotel, Chicago.
- March—American Otorhinologic Society for Plastic Surgery, Philadelphia.
- April 1-6—American College of Allergists Graduate Instructional Course and 18th Annual Congress, Hotel Radisson, Minneapolis.
- April 2-14—Postgraduate course in Laryngology and Bronchoesophagology, University of Illinois College of Medicine, Chicago.
- April 2-5—American College of Obstetricians and Gynecologists, Palmer House, Chicago, Illinois.
- April 6-13—American Academy of General Practice, Las Vegas, Nev.
- April 9-12—Aerospace Medical Association, Atlantic City.
- April 9-13—American College of Physicians, Bellevue-Stratford Hotel, Philadelphia.
- April 16-18—American Association for Thoracic Surgery, Chase-Park Plaza Hotels, St. Louis.
- April 23-28—American Academy of Neurology, Statler-Hilton Hotel, New York City.
- April 30-May 2—American Academy of Pediatrics, spring meeting, Statler-Hilton, New York City.
- April 30-May 3—American Proctologic Society, Deauville Hotel, Miami Beach.
- April—American Association of Pathologists and Bacteriologists, Queen Elizabeth Hotel, Montreal, Canada.
- May 6-10—American Association of Plastic Surgeons, Hotel Del Coronado, Del Monte, Calif.
- May 28-30—American Ophthalmological Society, The Homestead, Hot Springs, Va.
- May 29-June 2—American College of Cardiology, Denver Hilton Hotel, Denver, Colo.



THE ASSOCIATION

DEATHS

JAMES HAROLD NICHOLSON, 68, of Madison died November 12, 1961. Dr Nicholson was chief of staff at Morgan Memorial Hospital in Madison.

He received his medical degree from Emory University and his surgical degree from the University of Pennsylvania. He was a veteran of two World Wars and retired as an Army Colonel.

Dr. Nicholson was a former Mayor of Madison and former president of the Georgia Fox Hunters Association. He was past commander of the Calvin George Post, American Legion, and a member of the Medical Association of Georgia and the American Medical Association.

He is survived by his wife Gladys H. Nicholson; a brother, Joe R. Nicholson of Savannah; and a sister, Mrs. Earl Norman of Washington, Georgia.

HARRY B. NUNNALLY, 45, of Monroe died November 16, 1961 in an automobile accident.

He received his medical degree from Emory University Medical School in 1941 and did his residency at the Knickerbocker Hospital in New York. Dr. Nunnally served in the South Pacific during World War II.

Dr. Nunnally was a member of the Walton County Medical Society, the Medical Association of Georgia and the American Medical Association. He was a member of the First Baptist Church and their choir.

He is survived by his wife Edith Fugitt Nunnally and a son, Bill Nunnally.

PERSONALS

First District

CHARLES H. DRAKE of Glennville attended a postgraduate course at the Medical College of Georgia in "Fractures in General Practice" recently.

Second District

L. WALLERSTEIN and Lovick Williamson of Quitman have begun plans for a new and modern doctors' building.

Third District

AGATHA M. THRASH of Columbus was named as a diplomate of the American Board of Pathology last month.

W. McCALL CALHOUN is now associated with

R. A. COLLINS, JR. and **HARVEY L. SIMPSON, JR.** in Americus.

FRANK VINSON of Fort Valley attended the postgraduate course in "Fractures in General Practice" at the Medical College of Georgia recently.

HARVEY L. SIMPSON, JR., of Americus recently spoke to the Plains Lions Club on various diseases.

Fourth District

No news submitted.

Fifth District

TED F. LEIGH of Atlanta was the guest speaker at the December meeting of the New England Roentgen Ray Society in Boston.

Sixth District

JOE S. ROBINSON of Macon recently spoke to the Baldwin High School Student body on chest diseases. This was a follow-up on a film the students had seen.

WILLIAMS RAWLINGS of Sandersville and **BEN C. BARROW** of Monticello recently attended the post graduate course on "Fractures in General Practice" at the Medical College of Georgia in Augusta.

Seventh District

FRED H. SIMONTON of Chickamauga was guest speaker in December at the Annual Meeting of the Georgia Association For Mental Health.

Dalton doctors who were elected to the medical staff of the Hamilton Memorial hospital are: **CALVIN L. EDWARDS**, president; **JOHN LOOPER, JR.**, Medical staff secretary; **PAUL E. FITZPATRICK**, director of the Heart Clinic and **ELI A. ROSEN**, director of the Tumor Clinic.

DONALD R. ROONEY of Kennestone is the newly-appointed county radiological officer for Civil Defense.

DON W. SCHMIDT of Cedartown who is the District Governor 18-A Georgia Lions was the guest speaker for the Ellijay Lions the last of November.

Eighth District

The new officers of the Brunswick hospital staff are: **W. W. PAYNE**, chief; **JOSEPH B. MERCER**, vice president; **ROBERT E. PERRY, JR.**, secretary and **BEN T. GALLOWAY**, member at large.

Ninth District

Toccoa doctors attending the recent post graduate course in "Fractures in General Practice" were J. C. DUDLEY, JR. and ROBERT E. THOMPSON.

Tenth District

SHANNON GALLAHER of Augusta was recently the guest speaker at the local Kiwanis Club. She spoke on Tuberculosis.

CALHOUN WITHAM was the recent guest speaker at the meeting of the Wilkes County Heart Meeting.

EXECUTIVE COMMITTEE OF COUNCIL MEETING

THE EXECUTIVE Committee of Council December meeting was called to order by Chairman of Council George A. Alexander in the absence of the President or First Vice President, at 10:40 A.M., on December 10, 1961, at the Scott Hotel, Thomasville, Georgia.

Executive Committee members present were: George A. Alexander, Forsyth; Thomas W. Goodwin, Augusta; Milford B. Hatcher, Macon; John T. Mauldin, Atlanta; and J. G. McDaniel, Atlanta. Staff members present were: Mr. Milton D. Krueger, Mr. James M. Moffett and Mrs. Catherine Wooten.

Date and Site of Next Executive Committee Meeting

By general agreement of all members present it was decided that the meeting would be held on January 21, 1962, in Atlanta at MAG Headquarters, at 10:00 A.M.

There being no further business the meeting was adjourned at 10:45 A.M.

MEDICAL ASSOCIATION OF GEORGIA COUNCIL MEETING

THE MEETING OF the Council of the Medical Association of Georgia was called to order by Chairman George H. Alexander at 2:05 P.M., December 9, 1961, at the Scott Hotel, Thomasville, Georgia.

The invocation was given by Reverend Ben English of Thomasville.

Council members present were: George H. Alexander, Forsyth; Thomas W. Goodwin, Augusta; Lee H. Battle, Rome; J. G. McDaniel, Atlanta; Milford B. Hatcher, Macon; John T. Mauldin, Atlanta; Luther H. Wolff, Columbus; J. W. Chambers, LaGrange; Henry H. Tift, Macon; Edgar Woody, Jr., Atlanta; W. P. Jordan, Columbus; Walter Brown, Savannah; P. T. Scoggins, Commerce; George Dillinger, Thomasville; Charles E. Bohler, Brooklet; Frank Wilson, Leslie; F. G. Eldridge, Valdosta; C. T. Cowart, LaGrange; Virgil Williams, Griffin; Floyd Sanders, Decatur; James M. Hicks, Brunswick; Ralph W. Fowler, Marietta; C. R. Andrews, Canton; and W. Frank McKemie, Albany. Guests present were: Reverend Ben English, Thomasville; Julian Neel, Thomasville; Maurice Arnold, Hawkinsville; Mr. Richard Nelson, AMA Field Representative; and Mr. Frank Shackelford, MAG Attorney. Staff present were: Mr. Milton D. Krueger, Mr. James M. Moffett and Mrs. Catherine Wooten.

The minutes of the September 16-17 Council meeting, the October 8 Council meeting, the minutes of the Executive Committee meetings of September 17 and 21, October 8 and 15, and November 19 were reviewed by Mr. Krueger. On motion (Goodwin-Williams) it was voted to approve the Executive Committee action of October 15 to dispense with the reading of the minutes at the time of each meeting and to mail the minutes to each member of Council at the time of the mailing of the agenda for the subsequent meetings, but that minutes be reviewed.

Health Department Proposed Legislation on Recodification of Georgia Public Health Laws

Secretary Mauldin in Dr. Simonton's absence, gave Council information regarding the recodification of Georgia Public Health laws. Dr. Williams and Mr. Moffett also discussed the subject. Mr. Shackelford defined the corporate practice of medicine. Maurice Arnold discussed the actions of the State Board of Health.

On motion (Goodwin-Mauldin) it was voted that Council go on record as being opposed to that section of the recodification which constitutes the corporate practice of medicine; that this be communicated to the Chairman of the State Board of Health with a request for immediate consideration; that the Legislative Board of MAG be instructed to oppose in the Legislature the enactment of any laws regarding the corporate practice of medicine, and that Dr. John Venable be so notified.

Renegotiation of Medicare Contract

On motion (Mauldin-McDaniel) it was voted to authorize the renewal of the Medicare contract per the recommendation of Executive Committee.

SOCIETIES

ALTAMAHA MEDICAL SOCIETY recently had R. L. Lanier of Savannah speak to them on genetics.

BALDWIN COUNTY MEDICAL SOCIETY elected officers recently. They are: Edwin W. Allen, president; William Monroe, vice-president; and James G. Bohorfoush, secretary-treasurer.

BIBB COUNTY MEDICAL SOCIETY elected their new officers last month. They are: William R. Birdsong, president; E. C. McMillan president-elect; Calder Clay, vice-president; and Thomas DuPree, secretary.

SOUTHWEST GEORGIA MEDICAL SOCIETY elected their new officers in December. They are: Turner Rentz, president; W. H. Wall, vice-president; and R. E. Jennings, secretary.

JEFFERSON COUNTY MEDICAL SOCIETY re-elected their 1961 officers to serve again in 1962.

MUSCOGEE COUNTY MEDICAL SOCIETY recently elected James Rhea as president, and P. C. Grafagnino as president-elect. Secretary-treasurer is C. Denton Johnson.

OCMULGEE MEDICAL SOCIETY saw a movie in December shown by a Smith Kline & French salesman on closed chest cardiac resuscitation.

POLK COUNTY MEDICAL SOCIETY held their election of officers in December. The new officers include: Charles G. Rogers, president; Harold E. Goldin, vice-president; and T. E. Cummings, secretary-treasurer.

RICHMOND COUNTY MEDICAL SOCIETY recently elected new officers. They include: F. N. Harrison, president; Preston D. Ellington, president-elect; Curtis H. Carter, vice president; and William N. Agostas, secretary-treasurer.

STEPHENS COUNTY MEDICAL SOCIETY recently elected new officers. They are: Henry McNeely, president; Robert Thompson, vice-president; and Irving Hellenga, secretary.

WALKER-CATOOSA-DADE MEDICAL SOCIETY recently elected their new officers. They are: Robert T. Jones, president; Leroy Sherrill, president-elect; and John Ellis, secretary-treasurer.

Kerr-Mills Welfare-MAG Implementation Program

This report by Medical Director Mauldin was received for information. On motion (Mauldin-Hatcher) it was voted to defer any renegotiation of the Welfare Department contract on the purchase of equipment, due to availability of basic requirements in MAG Headquarters Building. Dr. Mauldin stated that information about the program would be in the JMAG January issue.

Podiatry Liaison Committee Report

Chairman Wolff read the Resolution drawn up by his committee as follows:

RESOLUTION

Whereas, the Medical Association of Georgia is primarily concerned with the quality of medical care rendered to the citizens of Georgia, and

Whereas, the Committee on Podiatry feels that the scope of surgical procedures requested by the Georgia Podiatry Association for payment of benefits under Blue Shield has not been adequately delineated and defined and

Whereas, a committee of the American Academy of Orthopedic Surgery is presently studying the problem of the scope of podiatry with the view of making recommendations to the American Medical Association, and

Whereas, no recommendation or clarification has yet been presented by the AMA,

Now Therefore Be It Resolved, that the MAG Committee on Podiatry recommends that the Council of the Medical Association of Georgia oppose the inclusion of Podiatrists under the Blue Shield Enabling Act, until such time as clarification can be obtained.

On motion duly made and seconded it was voted to adopt the above Resolution as recommended by the Podiatry Liaison Committee.

Report on Legislative Activity

Mr. Moffett discussed the agenda items of the Legislative Board meeting on December 7.

Appointment of MAG Treasurer

Acting Treasurer McDaniel read the motion of the Executive Committee meeting on November 19 as follows: "On motion (Goodwin-Alexander) it was voted that John S. Atwater be recommended as MAG Treasurer, to be confirmed by Council, and that he would assume office January 1, 1962." On motion (Hatcher-Williams) it was voted to approve the appointment of John S. Atwater as recommended by the Executive Committee.

Treasurer's Report and Report of Finance Committee Re 1962 Budget

Acting Treasurer McDaniel gave Council the Treasurer's report and the proposed 1962 budget. On motion (Goodwin-Chambers) it was voted to approve the Treasurer's report and the 1962 budget, and to commend the Finance Committee for its work.

SUMMARY — 1961 AND 1962 BUDGET THE MEDICAL ASSOCIATION OF GEORGIA

	1961 Budget	Actual 11 Months Ended Nov. 30, 1961	Proposed 1962 Budget
INCOME			
I. (a) MAG Dues	\$100,680.00	\$102,140.00	\$102,000.00
(b) Int. & AMA	800.00	1,438.51	1,200.00
(c) GP Service	2,820.00	2,585.00	3,250.00
(d) Funds Carr.			
1960	9,720.24	9,720.24	
II. Annual Session	9,625.00	9,800.00	8,225.00
III. Journal	50,000.00	32,164.36	38,000.00
Total Income	\$173,645.24	\$157,848.11	\$152,675.00

EXPENSES

I. (a) Fixed Allot.	\$ 14,300.00	\$ 6,559.29	\$ 13,450.00
(b) Assoc. Office	68,073.00	54,841.47	68,450.89
(c) Assoc. Boards	22,065.00	16,892.40	20,745.00
(d) Rel. MAG Act.	2,950.00	1,948.61	1,400.00
(e) Cont. Fund	14,123.99	7,554.49	4,077.91
II. Journal	52,133.25	38,114.96	44,551.20
Total Expenses	\$173,645.24	\$125,911.22	\$152,675.00

LIQUID FUNDS AVAILABLE

I. Cash in Bank	\$ 1,529.37
II. Sec.-U.S. Bonds	4,840.00
III. Savings Acct.	10,000.00
Brookhaven Fed.	
Sav. & Loan	
Citizens & Southern	30,000.00

MAG Awards Report

Mr. Krueger gave this report for Dr. Bishop, who could not be present: (1) Hardman Award (for scientific attainment): MAG to receive nominations to be turned over to a nine man secret committee appointed by the President, with the two deans of the medical schools as members and the President of MAG as Chairman for selection of recipient. On motion duly made and seconded it was voted to approve the recommended changes in the Hardman Award to be effective for the Annual Session year 1962-63 and thereafter, if approved by the 1962 House of Delegates.

MAG Annual Session Scientific Exhibits Chairman

Secretary Mauldin reported that upon the recommendation of the MAG Annual Session Board Chairman Peter Hydrick, Edgar Grady, of Atlanta, was submitted for consideration to the Executive Committee, and on motion duly made and seconded it was voted by the Executive Committee to approve his appointment subject to Council approval. On motion duly made and seconded it was voted to approve the appointment of Edgar Grady as MAG Annual Session Scientific Exhibits Chairman.

AMA Medicine-Religion Program

Mr. Krueger gave the AMA proposed program between Medicine and Religion. The entire program is for the betterment of patient care and will be instituted on a trial basis in four states. On motion (Mauldin-Hatcher) it was voted to ask the Chairman of Council to appoint a committee to bring in a Resolution for Council action on this program on Sunday, December 10. Chairman Alexander then appointed a committee composed of Virgil Williams, Chairman, J. W. Chambers and Walter Brown.

MAG House of Delegates Resolution No. 3

Secretary Mauldin reported that at Council's request at the September Council meeting, it was voted to direct the Secretary to write the Blue Cross Plans in Atlanta, Columbus and Savannah and protest the inclusion of certain professional services in the Blue Cross contracts. On motion, it was voted to request an answer and to inform Council of the replies to these letters. Dr. Mauldin read the answers from Atlanta and Columbus to Council. He also stated that letters had been mailed to the Presidents of the three specialty societies involved with copies of the Atlanta and Columbus letters enclosed.

This portion of the meeting was recessed at 5:05 P.M.

The Council meeting was reconvened at 8:30 A.M., December 10, 1961, at the Scott Hotel, Thomasville.

Indigent Physician Pension Plan

Dr. Mauldin discussed the difficulty of some county medical societies in putting in their share of the pension to an indigent physician. This matter had been referred to the Insurance and Economics Board for study. After due consideration by this Board, it was generally agreed that this matter should be handled by both the county medical society and MAG on an individual consideration basis only, and that the present matching formula be retained as is unless such individual consideration was presented to Council for any change. On motion (McDaniel-Williams) it was voted to accept the Insurance and Economics Board recommendation as stated above.

AMA-MAG Delegates Report

Henry H. Tift, Chairman of the MAG-AMA Delegates, gave a report of the AMA Clinical Session in Denver, November 26-30, 1961. Dr. Tift expressed appreciation for Dr. Eustace Allen's assistance. Dr. Mauldin recommended that the Alternate Delegates be given a small travel stipend to encourage them to attend the AMA meeting, and asked that consideration be given to this item at the time of the next meeting of the Finance Committee. Doctors Chambers and Dillinger gave further information regarding Reference Committee work. Dr. McDaniel suggested that due to lack of funds the Finance Committee not be asked to consider the expenditure for Alternate Delegates' expenses until next year.

AMA Medicine-Religion Program

The committee, which Chairman Alexander had appointed Saturday, December 9, to bring in a Resolution for Council action, was asked at this time to read the Resolution drawn up. Chairman Williams read the following:

RESOLUTION

Whereas, the Council of the Medical Association of Georgia is cognizant of the need of better liaison between the professions of medicine and the ministry, and recognizing the necessity of religious, as well as medical ministrations in good patient care, and

Whereas, the American Medical Association has established a Department of Medicine and Religion;

Therefore, Be It Resolved, that the Council of the Medical Association of Georgia endorses and supports the activities of the American Medical Association Department of Medicine and Religion in every way practical, both on the national and local level.

Virgil B. Williams, Chairman
J. W. Chambers
Walter E. Brown
MAG Council Committee

On motion (Dillinger-McDaniel) it was voted to adopt the Resolution as read and to send a copy of this Resolution to AMA.

Statewide Disaster Medical Care Meeting

Mr. Moffett and Dr. Mauldin discussed the plans of the Disaster Medical Care Committee for a statewide meeting. It was suggested that a display booth at the Annual Session, an editorial in the *JMAG*, or an all-member mailing might be helpful at this time rather than a statewide meeting, since the emergency situation, which prompted the idea of the meeting, has subsided. On motion (Goodwin-Hatcher) it was voted that Council should receive this report as information and that the Secretary should be asked to talk with the Chairman of the Committee to explain the feeling of Council regarding this meeting. Dr. Williams also

discussed the problem of resupply of emergency hospitals over the state.

4th Annual MAG County Medical Society Officers Conference

Mr. Krueger gave this report for information in the absence of Dr. Bishop. It was suggested that the Sunday morning session might be "toned down" to some extent.

Headquarters Office Report

Mr. Krueger thanked Council for approving the action of the Finance Committee in giving the MAG employees certain raises for next year.

AMA Field Representative Report

Mr. Richard Nelson made a few remarks regarding AMA activities.

Unfinished Business

(1) HEW Meeting, Nashville, November 7-10, 1961: Dr. Mauldin reported on his attendance.

(2) Vocational Education Hospital Housekeeping Supervisors Program: Dr. Hatcher discussed his conference with Miss Fannie Mae Walker regarding the possibility of establishing a program for the training of Hospital Housekeeping Supervisors and endorsement of said program by MAG. On motion (Hatcher-Dillinger) it was recommended that a physician be asked to serve on the Advisory Committee before a decision can be made regarding endorsement of the program.

New Business

(1) Ethical and Legal Conduct of Doctors of Medicine: Dr. Goodwin asked that the matter of the possibility of introducing a law through the Legislature regarding future legislation on the ethical and legal conduct of doctors of medicine be brought before the Legislative Board; for report back to Council, and for Council to refer to the House of Delegates. Dr. Scoggins was asked to serve as a representative of Council for the study of this problem.

(2) State Board of Health Request: It was suggested to the State Board of Health that its director, John Venable, be considered for an address at each MAG Annual Session on the state of health of the people of Georgia. On motion (Goodwin-Hatcher) it was voted to receive this report as information.

(3) Date and Site of March Council Meeting: On motion (Goodwin-Hatcher) it was voted to allow the Executive Committee to set the date and site of the March meeting.

(4) Thomas-Brooks County Medical Society: On motion duly made and seconded it was voted to thank the Thomas-Brooks County Medical Society and Dr. Dillinger for their hospitality to the Council members and staff at this December Council meeting.

There being no further business the meeting was adjourned at 10:15 A.M.

DECALCIFICATION OF BONE

John T. Godwin, M.D., Director of Laboratories
St. Joseph's Infirmary, Atlanta 3, Georgia

In order to hasten the displacement of calcium during decalcification of bone, the following simple procedure has been devised.

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Bone is rapidly decalcified with a significant reduction in time over that usually required with five per cent nitric acid.

Remember These Dates for Your Calendar

MAY 6-9, 1962

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of the

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References: (1) Malone, F. J., Jr.: *Mil. Med.* 125:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* 34:187, 1959. (3) Ullman, A.: *Delaware M. J.* 32:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* 108:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* 10: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* 11:392, 1960.

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Normal Myocardium, 600X.
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Photomicrograph: Robert Smith, Upton Long Island, New York.

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INSULIN RESISTANCE, A CLINICAL AND EXPERIMENTAL STUDY

Buris R. Boshell, M.D., James C. Barrett, M.D.
and James H. Carr, Jr., *Birmingham, Alabama*

■ *This condition is recognized more frequently now that the mechanisms are better understood.*

INSULIN RESISTANCE has been defined by Martin as a state which requires 200 or more units of insulin per day for longer than 48 hours to achieve diabetic regulation in a non acidotic person.¹ This definition is based on an old estimate of endogenous insulin production which is no longer tenable in view of more recent work which indicates that normal daily endogenous insulin secretion is probably no more than 50 units per day.²

Although there are relatively few reported cases of insulin resistance the condition is by no means rare. The author has collected ten such patients from the diabetic clinic of the University Hospital in Birmingham during the past year. These patients are of special interest from the standpoint of acute therapy in that failure to realize that unusually large doses of insulin may be required in times of stress can result in a preventable catastrophe. Among the extremes of insulin requirement is the patient reported by Shepard who required 56,080 units of insulin in 26 hours but who did not live long enough to meet the criteria for insulin resistance³. Russo reported a patient in 1950 whose requirement was such that the entire insulin supply of a university hospital was exhausted before normoglycemia was attained.⁴ Smelo reported a patient with chronic insulin resistance who required 1,250,000 units of insulin over a four-year period, an average of 850 units per day⁵. Most patients reported, however, have required be-

tween 200 and 400 units of insulin per day.

The natural course of insulin resistance is a varied one in that the excessive insulin requirement may disappear in days, weeks, months, or a few years. This fact has made evaluation of various therapeutic measures extremely difficult especially since most reports in the literature are based on no more than one or two patients. Severe ketoacidosis is said to be uncommon in patients with insulin resistance.⁶ Our observations do not confirm this statement.

Figure 1

POSSIBLE SITES FOR INTERFERENCE WITH INSULIN ACTIVITY

- BOUND IN TISSUES, INACTIVATED OR POORLY ABSORBED.
- (A.) BOUND INTRAVASCULARLY AND HELD
(B.) BOUND INTRAVASCULARLY AND INACTIVATED
- INTERSTITIALLY BOUND OR INACTIVATED.
- ACTION ANTAGONIZED, INHIBITED OR BLOCKED IN THE SERUM OR AT THE CELLULAR LEVEL.

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INSULIN RESISTANCE / Continued

Figure I summarizes possible sites at which factors might act to cause insulin resistance. The insulin could possibly be bound in the tissues at the site of administration rendering it inactive, or perhaps inactivated by an unusually potent enzyme system. Studies of insulin absorption from the site of injection utilizing I^{131} labelled insulin have revealed no consistent differences in diabetics and normals.⁷ Although Mirsky has demonstrated an increased insulinase activity in diabetics this activity is largely confined to the liver and kidneys therefore it is unlikely to be of great importance at the injection site⁸. Furthermore, if local binding or destruction were of much importance in causing insulin resistance the serum insulin-like activity in patients with resistance should be low. Leonard and Martin, Presland and Todd, and Shipp, et al have demonstrated high levels of insulin like activity in the serum of patients with chronic insulin resistance^{9,10,11}.

Absorption from Local Injection

The second thesis that perhaps the insulin is bound following absorption from the local injection site has been studied extensively and there is considerable information to indicate that this is an important factor. Berson and Yalow have demonstrated that serum from insulin resistant patients may bind up to 500 units per liter compared to a normal of 20 units per liter¹². Lowell¹³, Burrows, et al¹⁴ and Vallance-Owen¹⁵ have all presented data to suggest that plasma binding or the action of a circulating inhibitor are the principal causes of insulin resistance. Field, however, has demonstrated that ACTH can abolish insulin resistance without altering significantly the ability of the serum to bind large amounts of insulin¹⁶. Shipp, et al demonstrated biologic activity of the circulating insulin in their case of insulin resistance, by transfusing plasma from this patient to a recipient¹¹. A slow release of insulin from binding sites was suggested by a delay in hypoglycemic response and the prolonged time required for maximal hepatic uptake of I^{131} labelled insulin added to the donor plasma.¹¹ Although differences in technique employed by various investigators make actual comparative interpretations difficult, there is much to suggest that binding of the insulin by plasma proteins is an important factor in many instances of insulin resistance. Although some of the reported patients have later developed bouts of hypoglycemia over rather long periods, suggesting that the bound insulin is released in an active form from the binding sites, the fact that most patients with insulin resistance do not go through periods of overt hyperinsulinism is evidence that much of the administered insulin is inactivated. Elgee et al have noted that

the renal cortex and liver rapidly concentrate insulin that is administered intravenously.¹⁷ Mirsky has demonstrated a very active insulinase system in the liver and kidneys which he has found to be unduly active in diabetic patients⁸. Insulin however, appears to be protected from degradation by the liver in the presence of plasma from diabetic patients who have been treated with insulin¹⁸.

Serum Inhibitors

Insulin inhibitors in animal sera consist of a pituitary-adrenal dependent lipo-protein complex which has been isolated from normal and diabetic rat sera and which has been demonstrated to possess sufficient potency to inhibit the stimulating effect of a 0.3 milli-unit/ml. of added insulin on glucose uptake in vitro, utilizing rat diaphragms¹⁹. Randle and Young described a similar antagonist in the plasma of diabetic cats²⁰. Antagonists have been demonstrated in human plasma or sera in association with albumin²¹, alpha one globulin²² and with alpha two and beta globulins²³. The antagonist associated with albumin is found in the presence of uncontrolled diabetes even prior to initial therapy with insulin and it disappears following regulation of the diabetic. The alpha one globulin inhibitor is found only in diabetic acidosis. The inhibitors found in the alpha two and beta globulin fractions have been isolated from normal sera and have been demonstrated to actually interfere with glucose uptake by the rat diaphragm whereas the other inhibitors mentioned only antagonized the action of added insulin. The lipo protein antagonist from rats, the similar factor from the diabetic cat and the inhibitor which is found in association with serum albumin are all pituitary dependent. This is in accord with the noted frequency of a degree of insulin resistance in association with acromegaly and "Cushings" syndrome^{24,25}.

Antibodies of two types have been demonstrated in insulin treated patients. The first is a reagin type antibody which is responsible for the allergic type of skin reaction occasionally seen following insulin therapy²⁶. The second type, the nature of which has as yet not been clearly defined appears to be the blocking type²⁷. This factor will protect mice from convulsive doses of insulin, is heat stable, non-dialyzable and is located in the gamma globulin fraction of serum. This antibody is probably an important factor in many instances of insulin resistance.

Materials and Methods

Ten diabetic patients with classical insulin resistance were selected from the outpatient clinic of the University Hospital in Birmingham, Alabama. Table 1 lists the age, sex, maximum insulin dosage, duration of diabetes and of insulin resistance in these

Table 1

PT.	AGE	SEX	MAXIMUM INSULIN DOSAGE	DURATION OF DIAB. MELL. (YRS.)	DURATION OF RESISTANCE (MOS.)
MG	55	F	300	15	21
EK	67	F	240	14	24
GB	53	F	260	15	12
AT	56	F	225	4	8
FW	25	F	205	7	6
HT	72	F	205	22	18
AP	58	F	960	1	6
ML	42	F	540	11	3
WG	37	M	500	16	12 YRS.
AL	61	M	270	14	14

patients. These patients have been evaluated from the standpoint of endocrine, liver and renal function as well as checked carefully for the presence of infection. The results of this survey are listed in Table 2.

Table 2

ENDOCRINE, LIVER, KIDNEY FUNCTION :—

PT.	BUN (Mg.%)	LIVER	PITUITARY		ADRENAL	THYROID	GONAD
			SKULL FILM	FSH			
MG	16	Normal	Normal	61	Normal	—	PMP (F)
AT	—	Normal	Lg. Sella	176	Normal	Normal	PMP "
EK	18	Normal	Lg. Sella	50	Normal	Normal	PMP "
GB	46(KWD)	"	Normal	35	Normal	—	PMP "
AP	20	Normal	Normal	456	Normal	—	PMP "
HT	20	Normal	Normal	—	Normal	Normal	PMP "
FW	23	—	Normal	—	Normal	—	Normal Menses
AL	22	Normal	Normal	—	—	—	61 (M)
WJ	11	Normal	Normal	—	—	Normal	37 (M)
ML	16	Normal	Normal	—	Normal	Normal	PMP (F)

Serum insulin like activity was determined initially and at various times during the following course using a slight modification of the fat pad bioassay as described by Martin et al²⁸. This data is listed in Table 3.

Table 3

SERUM INSULIN-LIKE ACTIVITY (μ UNITS/ML.)

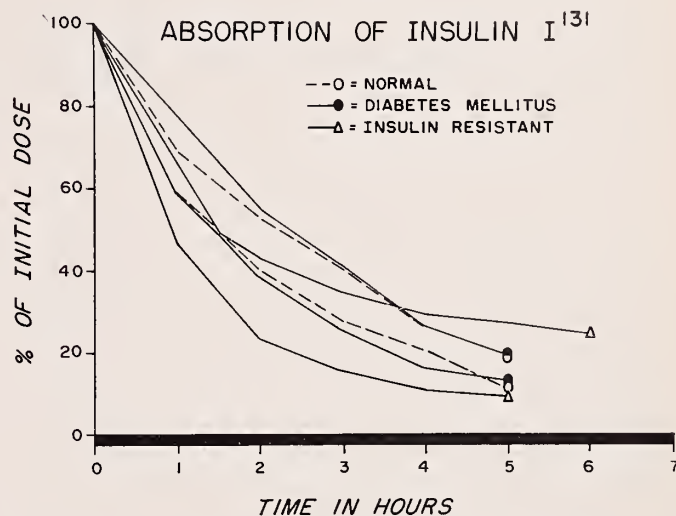
PT.	INITIAL LEVEL	\bar{p} ORINASE	\bar{p} CORTISONE	\bar{p} NITROGEN MUSTARD
MG	1,431 (1:4)	1,480 (1:8)	2,072 (1:8)	—
AT	1,000	2,558 (1:8)	—	—
EK	5,099	6,178 (1:8)	2,342 (1:8)	—
GB	2,347	—	—	—
AP	1,760 (1:8)	—	—	1,264
HT	329	3,288 (1:8)	—	—
FW	2,256 (1:8)	2,140 (1:8)	—	—
AL	1,280 (1:8)	1,308 (1:8)	—	—
WJ	1,223 (1:8)	—	1,603 (1:8)	—
ML	2,853 (1:8)	—	—	—

— GOOD RESPONSE TO THERAPY

— SLIGHT TO MODERATE RESPONSE

Disappearance curves of I^{131} labelled insulin from subcutaneous deposit sites were determined in two insulin resistant, two diabetics on insulin, and two normals. Fifteen to 30 microcuries of I^{131} insulin were administered subcutaneously and hourly counts were made over the injection site utilizing a Picker scintillation probe with a three-inch sodium iodide crystal and a pulse-height analyzer. The results of this study are seen in Table 4.

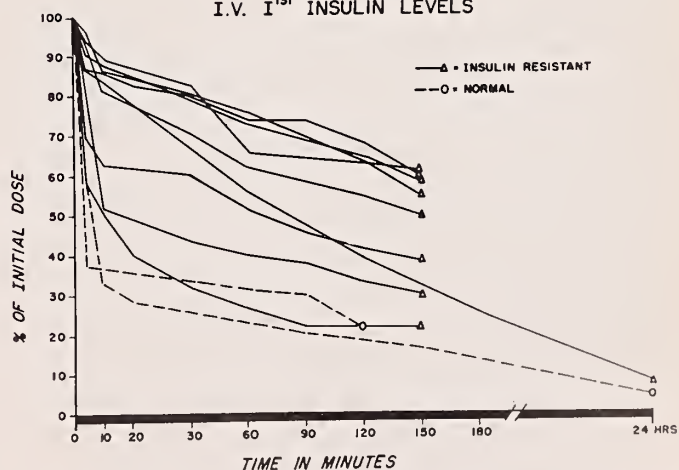
Table 4



Subsequently eight of the insulin resistant and two normal patients have received 100 microcuries of I^{131} labelled insulin intravenously following which periodic samples were taken, precipitated with trichloroacetic acid, (TCA), and each fraction counted. The disappearance curves as derived from the TCA precipitated material are shown in Table 5.

Table 5

I.V. I^{131} INSULIN LEVELS



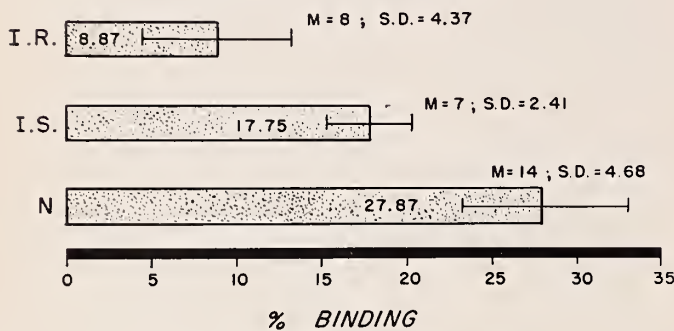
Sera from 14 normals, seven insulin sensitive and eight insulin resistant patients have been tested for resin binding utilizing the technique as described by Mitchell et al²⁹. These results are presented in Table 6.

Therapeutic regimens that have been tried in addition to steadily increasing the insulin dosage consist of tolbutamide, at a dose of three grams per day and meticorten, 80 mg. per day.

INSULIN RESISTANCE / Continued

Table 6

RESIN INDEX FOR NORMAL PERSONS,
INSULIN SENSITIVE, AND INSULIN RE-
SISTANT DIABETICS



Results

The ten patients with insulin resistance reported in this paper were selected from an indigent diabetic clinic with a patient population of approximately 1500. The age range was 25 to 72 years. Eight of the patients are females and two are males. Approximately three fourths of the clinic population is composed of females. The minimum daily dose for the patients when not in acidosis was 205 and the maximum 960 units. Duration of diabetes mellitus in this group ranged from one to 22 years. Seven of the patients have had diabetes more than ten years. Insulin resistance has been present in these patients from three months to 12 years. The resistant state has been present for more than one year in six of the ten patients.

Table two summarizes an evaluation of the renal hepatic, pituitary, thyroid and gonadal function in these patients. Although a number of tests were usually performed in the evaluation of these systems only the blood urea nitrogen is listed under the renal heading. Tests relative to hepatic status consisted of bilirubin, direct and indirect, BSP, alkaline phosphatase, serum iron and iron binding capacity, cholesterol and cephalin flocculation. All except one patient had a blood urea nitrogen greater than 15 mg. per cent; however, only one patient (G. B.) who has manifestations of Kimmelstiel-Wilson's disease had a definitely elevated level. Liver function was normal in the nine patients tested. Two patients (A. T. and I. K.) have evidence of pituitary tumor by skull x-ray but no evidence of acromegaly, visual field defects, etc. Patient A. T. does however, have a rather marked elevation of urinary follicular stimulating hormone as tested by the 21-day-old female mouse uterine bioassay. Patient A. P. was also noted to have a very high FSH level. Adrenal studies consisting of measurement of the 24-hour excretion of 17 ketosteroids and 17 hydroxy corticosteroids have been found within the normal range in nine patients tested. Thyroid function as deter-

mined by cholesterol, clinical evaluation, 24-hour radioactive iodine uptake and serum protein bound iodine is normal in the six patients tested.

Seven of the eight female patients in this study are post-menopausal. One patient (F. M. W.) age 25 years, has normal menstrual periods. One of the two male patients is impotent and the other professes to have normal sexual activity.

Table three summarizes the results of serum insulin like activity (I. L. A.) determinations in these patients. Serum for these studies was drawn in the fasting state, 24 hours after the last insulin injection. With this technique, undiluted fasting serum from apparently healthy adults show I. L. A. insulin like activity ranging from 30 to 500 micro units per ml., with a means of 270³⁰. Only one of these patients (H. T.) was found to have an I. L. A. within the normal range. The remaining nine patients had I. L. A. ranging from 1,000 to 5,099 micro units per ml. No consistent changes occurred in serum I. L. A. during therapy.

The six curves noted in **Table four** reveal no significant differences in the disappearance of I¹³¹ labelled insulin from subcutaneous deposit sites in normal insulin sensitive and insulin resistant patients. This is in keeping with the findings of Moore et al⁷. Moore's studies did not include any patients with insulin resistance but he found a mean disappearance T_{1/2} of 130 minutes in 11 normal patients and a mean T_{1/2} of 191 minutes in 22 insulin treated diabetics. The T_{1/2} in the six patients presented in Table 4 varied from 50 to 150 minutes. In fact the shortest T_{1/2} was in one of the patients with insulin resistance.

Table five summarizes our findings in eight patients with insulin resistance and two normals who were injected intravenously with 100 microcuries of labelled insulin. Here we see a rather striking difference in the disappearance of the labelled insulin from the sera of the resistant patients and the normals except for patient K. A. L. whose curve is within the normal range. Both of the normals but only two of the insulin resistant patients have less than 50 per cent of the tagged insulin still circulating in the plasma at the end of one hour. In fact both normals and one of the patients with insulin resistance are noted to have less than 50 per cent of the labelled insulin still circulating ten minutes following the injection. These findings are consistent with the observations of Mitchell et al³¹ that the hepatic uptake and the release times of the insulin I¹³¹ is considerably prolonged in the insulin resistant patients as compared to normals. Furthermore, it has been shown by Berson et al³² that the persistence of relatively high concentration of insulin I¹³¹ in the plasma of insulin treated subjects is due to the binding of insulin I¹³¹ by an acquired globulin which

possesses all of the characteristics of antibody. Yalow and Berson have further demonstrated that the apparent inhibition of liver insulinase activity by plasma or plasma fractions of insulin treated subjects is due to the complexing of insulin by insulin binding antibody³³.

Table six demonstrates the relative effects of sera from normals, insulin sensitive and insulin resistant diabetic patients on the resin index as defined by Mitchell²⁹. Sera containing insulin I¹³¹ is equilibrated in tubes with measured volumes of anionic resin. Following equilibration the tubes are removed and the radioactivity measured in a well-type scintillation counter. The resins are then washed with distilled water to remove the radioactivity that is not resin bound and the tubes are recounted. Radioactivity remaining on the resin divided by the initial radioactivity measures the fraction of hormone bound by the resin ("resin index"). Here we see a distinct separation of the normal, insulin sensitive and insulin resistant patients. This suggests that the binding capacity of serum for insulin progressively increases from normal to insulin sensitive, to insulin resistant patients in that order.

Three of the patients have shown an excellent response to tolbutamide therapy resulting in a decrease of their insulin requirement to less than 100 units per day. Two patients responded to prednisone temporarily but regained their insulin requirement following termination of the steroids. One who received a course of nitrogen mustards responded dramatically for approximately 48 hours with essentially a complete loss of need for exogenous insulin. Again the response was temporary.

Discussion

Insulin resistance is a well defined entity. It is not uncommon and failure to recognize its presence may result in an unnecessary fatality. There is no evidence to indicate that binding, destruction, or poor absorption at the site of injection plays any role in insulin resistance.

It is well established that antibodies to insulin occur and that they are important factors in the binding or complexing of administered exogenous insulin³⁴. The findings of Berson and Yalow that serum from certain insulin resistant patients may bind up to 500 units of insulin per liter suggests that binding may be an important factor in some cases of insulin resistance¹². However, the fact that complexing of the insulin with antibody protects it from insulinase activity would appear to decrease rather than increase the requirement for insulin³³. Furthermore, the complexing is reversible as has been demonstrated by Skom and Talmage³⁵, and by Berson and Yalow³⁶, yet the patients requirement for large doses of insulin may continue for many

years without evidence of hypoglycemia. On the other hand some patients with insulin resistance have bouts of hypoglycemia over prolonged periods without further administration of exogenous insulin at the time their insulin resistance begins to disappear^{37,12}.

Demonstration of high levels of I. L. A. in patients with insulin resistance is further support for the importance of binding or complexing of insulin resistance to prevent its physiologic action^{9,10}. Not all insulin resistant patients however can be demonstrated to have high serum I. L. A.³⁸ Field found that ACTH abolished insulin resistance in one patient without altering the ability of the serum to bind large amounts of insulin¹⁶. There are theoretical objections to the specificity and range of measurement in the technique used by Field and recently Prout and Katims have reported a patient in which methyl prednisolone lowered both the serum binding globulin and the insulin requirement³⁹. Oakely treated six insulin resistant patients with prednisone. The four patients with demonstrable antibodies responded whereas the other two did not⁴⁰. The most damaging argument against binding or complexing being the major factor in insulin resistance is the fact that the complex appears to be reversible, to protect the insulin from enzymatic degradation and does not explain what eventually happens to the thousands of units of exogenous insulin which never cause an observed physiologic effect. Perhaps the insulin is acetylated or modified in some other manner while still complexed thereby being released as a physiologically inactive molecule.

The possibility that interstitial binding or inactivation occurs or that the physiologic action of insulin is antagonized at the cellular level must remain speculative at the moment.

Many therapeutic measures have been tried in insulin resistance, the most consistently helpful one of which has been to give adequate amounts of insulin. The success of tolbutamide is of interest and perhaps represents a stimulation of endogenous insulin release in patients whose resistance is only to exogenous insulin and not to endogenous human insulin. Lowell⁴¹ and Sherman⁴² have reported patients who were resistant to beef and pork insulin but not to the human variety.

Conclusions

1. Insulin resistance is not a rare condition.
2. A review of the literature and evaluation of ten additional patients reveals no unusual association of insulin resistance with other disease states.
3. The mechanism of acquired resistance appears to be multifactorial. Some, but not all of the patients, have evidence of binding antibodies and high circulating levels of serum insulin like activity. In-

INSULIN RESISTANCE / Continued

creased levels of destruction or inactivation would still appear to be necessary in order to account for long term, large insulin requirements.

4. The most important therapeutic measure known is administration of adequate insulin. Adrenal steroids are effective in a few patients and tolbutamide in others. Success with steroids is more likely to occur in patients with demonstrable antibodies. Tolbutamide possibly produces its effect by stimulating the beta cells to release endogenous insulin. Some patients have a cross resistance to insulin from all species tested whereas others have antibodies against beef and pork but not human insulin.

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SUBACUTE BACTERIAL ENDOCARDITIS ASSOCIATED WITH AN OSTIUM PRIMUM DEFECT AND CONGENITAL ANOMALIES OF THE MITRAL AND AORTIC VALVES

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■ *This rare combination of pathologic findings is documented by a case report.*

THE CASE WITH the interauricular septal defect of significance, even when associated with mitral stenosis, so rarely develops infective endocarditis, that its occurrence is a pathological curiosity.¹¹ This rarity of subacute bacterial endocarditis in cases of interatrial septal defect has also been commented upon by Friedberg,² Taussig et al,³ and Abbott.⁴

Gelfman and Levine,⁵ reporting 181 autopsy cases of congenital heart disease in patients over two years of age, describe interatrial septal defect as the most common lesion encountered, occurring in 40 per cent of the cases. Thirty cases of subacute bacterial endocarditis occurred in the entire group, but none was seen in the patients with interatrial septal defect. In Roesler's⁶ series of 62 autopsy cases of interatrial septal defect, he reports that no subacute bacterial endocarditis was encountered. Bedford et al,⁷ in a series of 53 autopsy cases of interatrial septal defect, describe one case of subacute bacterial endocarditis; however, the endocarditic vegetations were in the left atrium, with neither interatrial septal defect nor mitral valve involvement. A similar case is reported by Griffith,⁸ a patient with interatrial septal defect and pulmonic stenosis, in whom the interatrial septal defect was free of disease, but endocarditic vegetations were found on the pulmonic valve. Goetsch⁹ describes a case of

subacute bacterial endocarditis in a case of atrioventricular communis; and Jacobius and Moore¹⁰ list one case of subacute bacterial endocarditis involving a patent foramen ovale, with subacute bacterial endocarditis vegetations on the limbus of the fossa ovalis and of the mitral valve, but give no details.

Case Report

Mrs. E. K., 17195, a 48 year old Negro female, was admitted to another hospital with a three week history of generalized aching, progressive weakness, malaise, fever, chills, sweating and anorexia. One week before admission the patient was first seen by a private physician because of a sore throat, generalized aching and stiffness of the neck. During the ensuing week her temperature ranged from 101 to 103.4 F., without response to salicylates and small doses of an oral antibiotic (type not recorded). Three days prior to admission scleral icterus and right upper quadrant tenderness were noted.

The patient reported a "life long heart condition," characterized by dyspnea on mild exertion and episodes of palpitation. This illness was never further studied or treated. Five years prior to admission the patient received a series of 25 injections for an unknown illness.

Physical examination as recorded was rather cursory and revealed the following significant features: The patient was described as a chronically ill appearing, slender, middle aged woman. Her temperature was 102 F., respirations 22/min., pulse 96/min., and blood pressure 90/60 mm. Hg. There

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ENDOCARDITIS / Continued

was considerable pallor of the mucous membranes and moderate scleral icterus. The neck veins were not distended and there were no murmurs or thrills in the neck. The heart was enlarged both to the right and the left, with a palpable systolic thrill in the fourth left intercostal space. The second sound at the pulmonic area was greater in intensity than the second sound at the aortic area. A grade III to IV harsh systolic murmur was heard throughout the precordium, with maximum intensity in the fourth left intercostal space. A grade II decrescendo diastolic murmur was heard along the upper left sternal border. The lung fields were clear to percussion and auscultation. The liver edge was palpable three fingerbreadths below the right costal margin and was markedly tender. There was no lymphadenopathy or splenomegaly. Slight costo-vertebral angle tenderness was elicited bilaterally. There was minimal nuchal rigidity, but the remainder of the neurological examination was unremarkable. No mention was made of petechiae or splinter hemorrhages.

Laboratory Findings

Laboratory examination showed a hemoglobin of 6.8 grams per 100 cc. and a hematocrit of 25 per cent, with the red blood cells described as hypochromic and microcytic. The white blood count was 25,300 per cu. mm. with 75 per cent polymorphonuclear leukocytes, six per cent band forms, 14 per cent lymphocytes (six atypical), and four per cent monocytes. Urinalysis showed a pH of 5.0; specific gravity 1.013; sugar negative; albumin one plus; 15 to 17 white blood cells per high power field and no red blood cells, casts, or bacteria. The VDRL was non-reactive. Total serum bilirubin was 2.35 mg. per 100 cc. with 0.93 mg. per 100 cc. direct bilirubin; serum albumin was 3.8 gm. per 100 cc. and globulin 3.2 gm. per 100 cc. (albumin 2.4 gm. per 100 cc. and globulin 4.8 gm. per 100 cc. on repeat determination); and thymol turbidity 11.0 units. Heterophile agglutination was 1:14. Typhoid and brucella agglutination tests were negative. Two blood cultures were reported to show hemolytic *Staphylococcus aureus*, coagulase positive. An EKG was not obtained. A PA chest film showed concentric cardiac enlargement with marked engorgement of the pulmonary vessels.

The admission diagnosis was viral hepatitis; the patient was treated with bed rest, salicylates for the fever, and a high protein low fat diet. Because of the persistent fever, antibiotics were administered in this manner: *Terramycin* 200 mg. daily for one week, followed by *Ilosone* one gram daily and penicillin 1,200,000 units daily for one week, and then

Chloromycetin one gram daily for the last four days of life. The fever persisted throughout, varying from 99 to 102 F. and not being appreciably affected by the antibiotics administered. The patient was digitalized after the first week of hospitalization; neither the indications nor the response are apparent from the hospital chart. In addition, two units of whole blood were administered without a change in the hemoglobin level.

The patient died on the 19th hospital day without an apparent acute incident. It should be noted that neither of the authors knew of this patient during life.

Autopsy Findings

Autopsy was performed at the Grady Memorial Hospital and was limited to the abdominal and thoracic viscera. The pericardial cavity contained 275 cc. of thin, clear, straw-colored fluid. Visceral and parietal pericardial surfaces were grey-white, smooth and glistening. *In situ* examination of the heart revealed marked alteration of configuration. There was dilatation of the right atrium and right ventricle, with striking dilatation of the pulmonary conus and pulmonary artery (Figure 1). The left atrium was also moderately dilated.

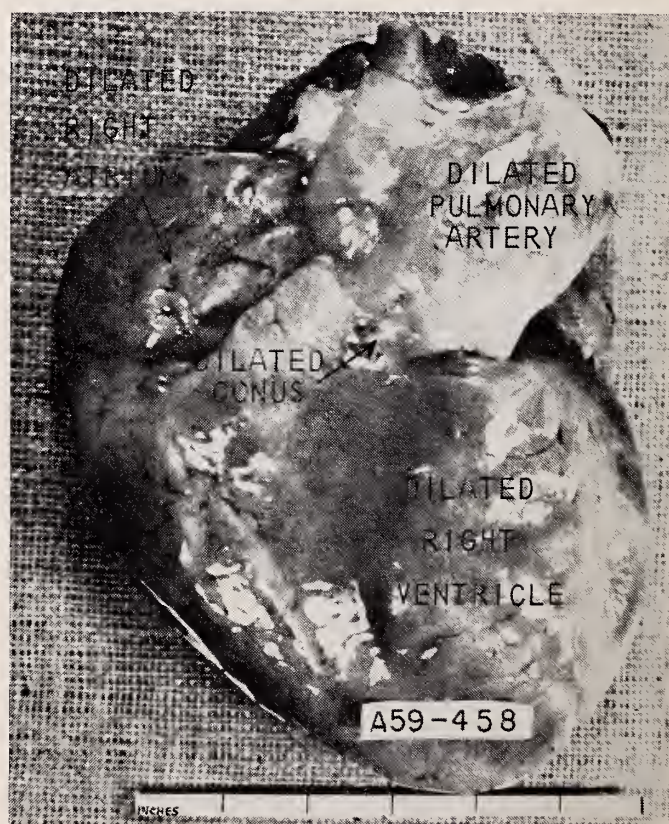


Figure 1. Anterior view of the heart and great vessels.

After removal from the body, the heart was opened by the method of Rokitansky. An ostium primum type interatrial septal defect, measuring 3.5 cm. in greatest diameter, was noted (Figure 2). The tricuspid valve was dilated, with the circumference of the valve ring being 20.0 cm. Dilatation

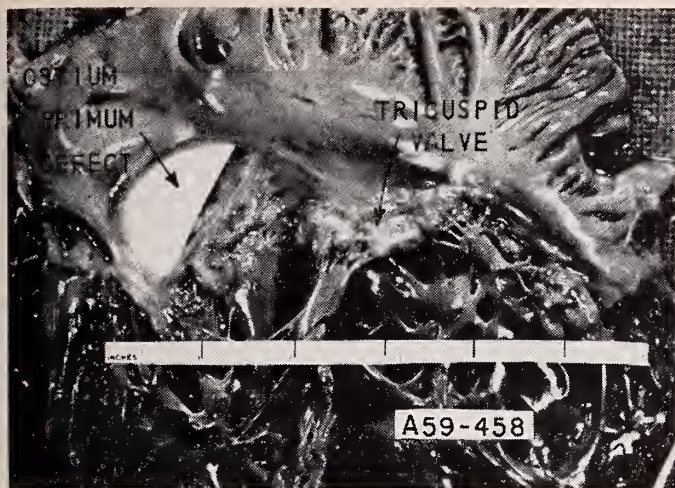


Figure 2. Interior view of the right side of the heart.

of the right ventricle was apparent, and the thickness of the right ventricular wall averaged 0.8 cm. Again, marked dilatation of the pulmonary conus was noted, and the circumference of the pulmonary valve ring was 13.0 cm. Soft, yellow atheromata were observed in the intima of the pulmonary artery, most plentiful in the main stem pulmonary artery and the primary and secondary branches, but also seen in the finer radicles. The entire pulmonary arterial tree was greatly dilated in all its ramifications.

An unusual anomaly of the mitral valve was seen, consisting of a cleft in the right leaflet giving the valve a "double-barreled" appearance as viewed from above. On the inferior surface of the right leaflet, chordae tendineae were observed to be attached to the edge of the cleft as well as to the free edge of the leaflet. A friable, reddish-brown, verrucous vegetation, measuring 1.5 X 0.5 X 0.3 cm., was present on the superior aspect of the right leaflet located between the free edge and the cleft (Figure



Figure 3. Interior view of the left side of the heart with opened mitral valve.

3). Microscopically, the vegetation consisted of fibrin and colonies of cocci, with ingrowth of fibroblasts at its base. Cultures of the vegetation grew hemolytic

Staphylococcus aureus, coagulase positive. The mitral valve ring circumference was normal, 10.0 cm.

The chamber of the left ventricle was normal in configuration and the thickness of the ventricular wall was 1.0 cm. The aortic valve was abnormal in that each cusp was fenestrated (Figure 4). There was



Figure 4. Aortic valve.

no evidence of endocarditis on the aortic valve. After dissection, the heart weighed 710 gm.

Peripheral embolization was evident only as septic splenic infarctions, varying from 1.0 to 2.5 cm. in diameter (Figure 5). Microscopically, these infarcts

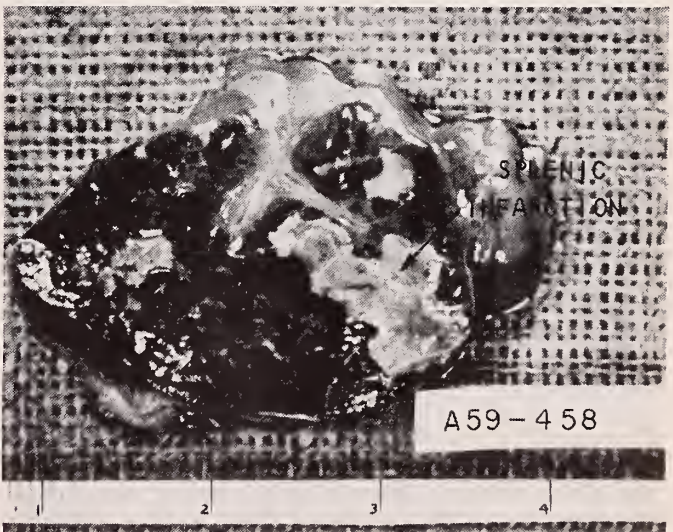


Figure 5. Cut Surface of the spleen.

tions were areas of coagulation necrosis with colonies of cocci and foci of liquefaction necrosis scattered throughout the infarcts.

The pleural cavities each contained 20 to 30 cc. of thin, clear, straw-colored fluid. The parietal and visceral pleurae were translucent, smooth and glistening. After removal from the chest, the lungs were observed to retain their shape. Both lungs were excessively heavy, the right weighing 1050 gm. and the left 900 gm. The parenchyma of both lungs was discolored by dark-red areas throughout, and

ENDOCARDITIS / Continued

large amounts of watery, blood-tinged edema fluid could be expressed with ease. The presence of massive pulmonary edema and vascular congestion was confirmed microscopically.

The liver was enlarged, weighing 2000 gm., and the free edges were blunted. Dense, grey-white, fibrous adhesions bound the right lobe of the liver to the diaphragm. On cut surface, the vascular pattern was prominent, and the parenchymal consistence was increased. Microscopically, there was moderate cardiac cirrhosis with centrilobular congestion.

Other findings were arteriolar nephrosclerosis and a leiomyoma of the uterus. The remainder of the post-mortem examination showed no remarkable morphologic lesions.

Summary and Conclusions

It has been emphasized that bacterial endocarditis is rarely seen in cases of atrial septal defect, even

when associated with deformities of the mitral valve. Accordingly, this case of subacute bacterial endocarditis associated with an ostium primum defect and congenital anomalies of the mitral and aortic valve has been reported and the literature reviewed.

80 Butler Street

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THE CONTINUING EDUCATION OF THE PHYSICIAN

Stewart G. Wolf, M.D.

*Reprint From Journal of the Oklahoma State
Medical Association*

No one denies that a career in medical practice requires that the physician be a perpetual student. The problem is how to acquire adequate and appropriate learning over the years. There are three educational resources available to every physician: 1. his day-to-day experience in practice; 2. the medical literature; 3. medical meetings, including postgraduate courses.

The value of medical practice as a learning experience depends in part on one's sophistication derived from the literature, and from meetings and courses. What seems like limitless expansion of the medical literature, however, has imposed a crushing burden on those who wish to keep up. The result is that many physicians make no attempt to cover the literature and read only irregularly and in a casual fashion. Thus the medical literature is educating to any substantial degree only a small segment of the profession.

Similarly, medical meetings and postgraduate courses have a relatively small number of adherents. The very active and education-minded American Academy of General Practice has managed to attract only approximately 20 per cent of general practitioners to its membership.

How can continuing education be brought to more physicians at a time when their need is great, when the practitioner of today is faced with far more complex diagnostic procedures, far more delicate problems of achieving metabolic balance in post operative patients, and with far more potent and potentially hazardous drugs at his disposal than the practitioner of yesterday ever dreamed of?

The American Heart Association has taken cogniz-

ance of this problem and, through its Professional Education Committee, has inaugurated a program of pilot projects in continuing education which will be tried in various parts of the country and which will be evaluated insofar as possible for their effectiveness in teaching.

The American Heart Association plan grew out of a two-year long study by the Professional Education Committee of current practices in relation to continuing education. The experience and advice of men in practice, in medical schools, and in the field of education were brought together in a "white paper" entitled: The Physician's Continuing Education.

The study recognized that the cultivation of a physician's analytical powers, and thus to sharpen his diagnostic acumen and to enrich his clinical judgment, is a far more important objective than bringing him abreast of technical developments in medicine.

It was agreed that such an aim would require that the learner-physician be an active participant in the educational procedure and not just a listener. Opportunities must be afforded him to work with actual clinical problems in the course of the teaching program.

One important conclusion of the study was that the widespread lack of interest among practitioners of medicine in postgraduate courses may be related in part to inadequacies in the program being offered. Certainly there is a need for fresh and imaginative approaches to the problem of motivating the physician toward his continuing education and of offering him experiences which warrant him spending time, money and effort away from his patients.

MUSCLE RELAXANTS FOR ABDOMINAL PROCEDURES ON THE POOR RISK PATIENT

Charles R. Allen, M.D., *Galveston, Texas*

- ***During recent years there has been a marked increase in the number of patients with low cardiovascular and ventilatory reserves who are subjected to lengthy anesthetic and surgical procedures.***

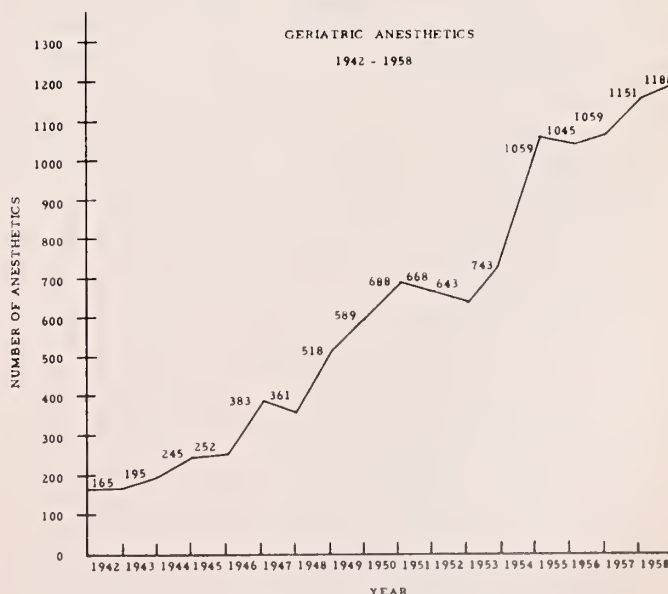
PRIOR TO 1940 curare was a medical curiosity. Good muscle relaxation was often a challenge to the experienced anesthetist who wished to produce satisfactory working conditions for the surgeon without also producing cardiovascular depression with profound anesthesia. Because of this challenge the effects of physiological positioning, plasma carbon dioxide variations, tissue hypoxia and the inherent muscle relaxing properties of the various regional and general anesthetic drugs received careful laboratory and clinical evaluation. From these studies it was realized that with the patient in physiologically proper positions on the operating table, with the maintenance of normal $p\text{CO}_2$ and blood O_2 tensions and with the selection of proper anesthetic agents, adequate muscle relaxation could usually be maintained without long periods of deep anesthesia. The advent of d-Tubocurarine and succinylcholine then made it possible to produce excellent relaxation by adding only small amounts of these specific muscle relaxants.

Unfortunately, physiological considerations in anesthetic management may be ignored but profound muscle relaxation still be obtained if larger amounts of d-Tubocurarine or succinylcholine are administered. Results of such management are reflected in many of the cardiovascular crises in surgery as well as periods of prolonged respiratory and circulatory depression in the recovery room. During the past decade there has been a marked in-

crease in the number of patients with low cardiovascular and ventilatory reserves who are subjected to lengthy anesthetic and surgical procedures. This category would include the majority of elderly patients as well as the seriously ill patients in most any age bracket.

When one considers the very narrow margin of safety within which the surgical team must often limit its permissible errors it is apparent that the anesthetist must also temper his techniques to insure the utmost safety to the patient and at the same time recognize and fulfill the requirements of the surgeons.

FIGURE 1



Presented at the 107th Annual Session of the Medical Association of Georgia, May 8, 1961.

MUSCLE RELAXANTS / Allen

Figure 1 illustrates the rise in anesthetics for geriatric patients in our own hospital during the past 17 years. During this same period the total output of our surgical suite was only doubled. Two-thirds of our elderly patients were between the ages of 60 and 70 years while the remainder were 71 and over. Figure 2 shows the incidence of preoperative complications that were evident from a review of our records on about 7000 elderly patients subjected to anesthesia and surgical procedures during the years 1942-1956. Only the leading symptom or the most serious complications which characterized the patient's physical condition were considered. It is apparent that longer and technically more difficult surgical procedures will be attempted as research in geriatrics progresses. As we review the mortality and morbidity results from our management of these individuals we are impressed by the fact that they usually do well in the operating room provided the physicians limit themselves to a very narrow margin of error.

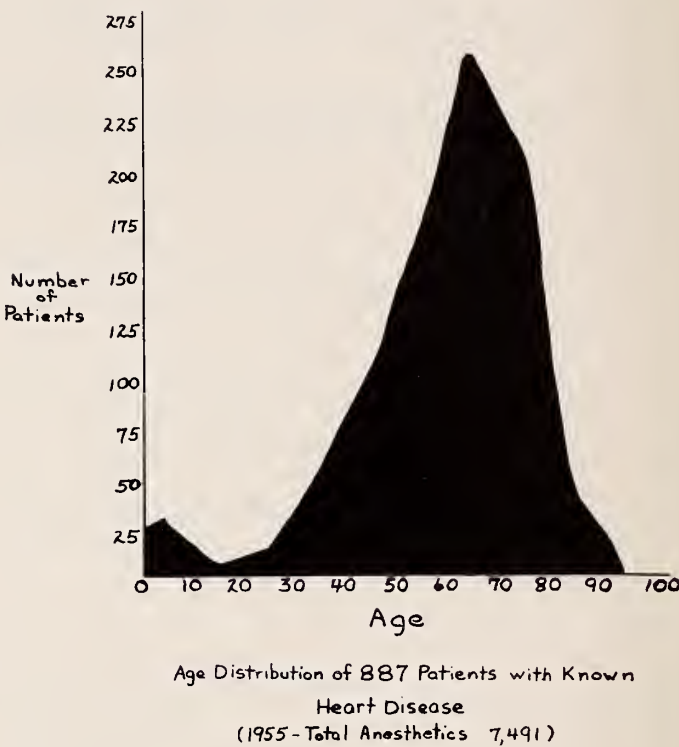
FIGURE 2
Predominant Preoperative Complications in 6,996 Geriatric Patients

	Number of Patients	Per Cent of Total
Hypertension (Syst. B.P. more than 175 mm.)	1,142	16.3
Organic Heart Diseases	974	13.9
Pulmonary Complications	806	11.5
Toxemia	686	9.8
Generalized Marked Arteriosclerosis	529	7.6
Severe Anemia (Hb. below 10 gm.)	391	5.6
Miscellaneous	859	12.3
Free of Any Systemic Disorder	1,609	23.0
Total	6,996	

Another indication of the ever increasing challenge to the surgeon and the anesthetist is the incidence of patients with cardiovascular disease who are scheduled for major surgery. A study of the records of 7,491 anesthetics administered in 1955 revealed the fact that 887 of our patients had "known" cardiovascular disease. Although most of these patients were elderly, Figure 3 indicates that individuals in this "poor risk" category were in all age groups. The average length of anesthesia for this group of patients was two hours and 30 minutes; however, some procedures lasted as long as eight to ten hours. Very few individuals with "previously known" extensive heart disease die in the operating room. However, in many patients who have died on the operating table, cardiovascular disease has been found to have played a major role in the demise although it was "unknown" and there-

fore was not given a major consideration in the election of anesthetic procedure and surgical convenience.

FIGURE 3



Almost any anesthetic agent in general use today when employed by an experienced anesthesiologist will be well tolerated by patients with extensive heart disease. Any anesthetic agent, however, may precipitate cardiovascular failure when improperly applied. An anesthetic drug or combination of drugs which prove highly successful when used by one anesthetist may fail miserably when employed by an individual inexperienced in their use. This latter individual may produce conditions equally well tolerated by the patient if he chooses agents whose limitations he knows well. In our experience in managing individuals in the elderly and seriously ill categories we have found light cyclopropane or light ether anesthesia to be the agents of choice for us. If other agents such as sodium pentothal, nitrous oxide or fluothane are used the addition of d-Tubocurarine or succinylcholine will often be necessary.

For procedures within the abdomen, the major problems of the anesthetist frequently is that of staying within the limits of safety in the anesthetic management of the patient with limited reserve and at the same time providing adequate relaxation of the abdominal musculature for the surgical procedure.

The proper physiological position of the "poor risk" patient on the operating table may be the determining factor in his ability to withstand the effects of sufficient anesthetic agents and muscle

relaxant drugs to provide a relaxed abdomen. The supine horizontal reflex-abdominal position is the position in which surgery is best tolerated by the anesthetized individual with limited compensatory ability.¹ In many instances positions are used which are poor physiologically. The majority of patients will temporarily adjust to extreme positions by the utilization of compensatory vasomotor and respiratory changes. Many individuals with systemic disease are unable to make adequate adjustments and within a short time manifest signs of physiologic distress by either respiratory or cardiovascular changes or a combination of the two.

If it becomes necessary to place a patient in a position other than the horizontal, good abdominal muscle relaxation by the use of deep anesthesia or the relaxant drugs may result in respiratory or cardiovascular distress. Difficulties of this type most often begin as the result of the venous and capillary stasis in dependent extremities or as the result of the splanchnic pooling of blood.

Venous Return

There are four factors which normally aid the venous return in raising the blood against gravity. If any or several of these factors fail, the accumulation of blood in the dependent parts is likely to occur.

The first factor of venous return is the impetus given the blood by the contraction of the left ventricle. Myocardial depression may result directly from high concentrations of most of the anesthetic drugs or it may result from hypoxia secondary to ventilatory insufficiency accompanying the muscle relaxant drugs.

A second factor is the support of the vein walls due to the tonus of the abdominal and limb muscles. The intermittent contractions of the skeletal muscle fibers which, in conjunction with the valves of the veins, propel the blood in the upward direction is decreased and often abolished by anesthetics and especially by relaxants.

A third factor is the suction and force-pump action of the great veins produced by normal respiratory movements. This factor is reduced by drugs which reduce respiratory muscle tone, retractors and other pressure on the rib cage, as well as intra-abdominal packs against the diaphragm.

As the fourth factor, the vasopressor and capillary tonus mechanisms control the caliber of the veno-capillary vessels of the splanchnic area and prevent the venous blood from becoming pooled in the abdomen at the expense of the effective circulatory volume in other regions. Autonomic response to surgical manipulation in lightly anesthetized but paralyzed patients may produce stagnation of blood in the splanchnic area.

Positioning

As long as the patient with muscle paralysis is in the supine horizontal position the effects of gravity are annulled but at least three of the four factors for venous return are depressed or obliterated. If the surgical procedure demands a position other than the supine horizontal, muscular relaxation must be less complete and in patients with low compensatory ability, the use of relaxant drugs may be contraindicated.

Consider for a moment the reverse Trendelenberg position which has recently been advocated for surgical repair of a hiatus hernia.² Wrapping of the lower extremities to the knees will not offset the pooling of blood in the thighs and splanchnic areas if the skeletal muscles are made flaccid.

Steep Trendelenberg position is also poorly tolerated by the patient with little reserve. The diaphragm during the inspiratory phase must lift the weight of the abdominal contents. If muscle relaxants have been used and the ventilation is assisted excessive pressure must be applied to the alveoli and pulmonary capillary bed in order to not only expand the lungs but also lift the abdominal contents which are resting on the diaphragm. The cardiac output is decreased and the arterio-venous oxygen difference is increased over the values obtained with the patient horizontal. Depression of skeletal muscle tone will aggravate this distressful situation.

The high "gall bladder" rest sometimes used with the position for cholecystectomy necessitates profound anesthesia or large amounts of the muscle relaxant drugs in order to remove the tension of the stretched abdominal musculature. Interference with venous return from the lower extremities may develop due to partial collapse of the inferior vena cava as it is stretched against the hyperextended vertebral column.

Although in many instances the surgical procedure demands positions other than the supine horizontal, our efforts in positioning, especially of patients with low compensatory powers, should be to avoid the extreme variations. In the anesthetic management of these patients we must remember that deep anesthesia or the use of muscle relaxants may be hazardous in that either drug may remove the patient's ability to return blood to the heart against the pull of gravity.

Mortality

In a study of mortality statistics in elderly patients, we found that only eight of 5,000 of these individuals died during anesthesia and surgery.³ However, 98 patients died during the first 72 hours of the postoperative period. It was obvious from our review that the immediate postanesthesia return of

MUSCLE RELAXANTS / Allen

reflexes and the restoration of both skeletal and smooth muscle tone are essential if major complications which contributed to these deaths are to be avoided in others.

In this regard, the question may well be asked as to whether there is a significant difference between the speed of recovery of individuals maintained for long periods of time with intermittent injections of d-Tubocurarine or succinylcholine as compared to those maintained in an apneic state for similar periods with a continuous succinylcholine drip. It is our clinical belief that those managed by the latter technique are more apt to experience prolonged depression in the recovery area. In our early experience with succinylcholine we attributed such depression to a deficiency of choline esterase. It has been shown, however, that frequently the choline esterase activity has been brought up to normal limits without noticeable improvement⁴.

Another reason for this depression may be suspected if we consider the effects of prolonged depolarization upon smooth and striated muscle cells. The initial response of the cell to succinylcholine is one of contraction as the actin and myosin come together while the sodium ions enter the cell and potassium ions are extruded into the extracellular fluid. Following the initial contraction the muscle cell relaxes but is held in a depolarized condition without being able to recapture the potassium ions or extrude the sodium. As the condition of heavy depolarization continues for several hours the muscle cell suffers from potassium depletion and enters a state of exhaustion atonia. In this condition vascular muscle can no longer respond to its natural stimuli, such as epinephrine or norepinephrine, for it cannot lose any more potassium and become still more depolarized⁵. Skeletal muscle cannot regain its tone either until repolarization occurs. The correction of the atonia, whether vascular or skeletal, will depend upon the correction of the sodium and potassium concentrations in both the extracellular and the in-

tracellular spaces. If the extracellular potassium has been removed by the circulatory system repolarization cannot take place even though the succinylcholine has been metabolized. In such instances the administration of additional potassium might correct the situation.

If during the prolonged period of muscular paralysis and depolarization the cells have become hypoxic and acidotic because of ventilatory difficulties or sluggish blood flow there may be adequate potassium in the extracellular fluid but the metabolism may be upset to the extent that energy is not available to expel the sodium against the much higher extracellular gradient and bring back into the cell the potassium. In instances of this type glucose-insulin solution is said to carry potassium into the cell and also be available as a readily oxidizable substrate for cell metabolism.

It is my hope that even though my treatment of these subjects has been most inadequate, three points have been put forth. (1) There is an ever increasing number of poor risk patients coming to the operating rooms for anesthesia and lengthy surgery; (2) the supine-horizontal or "reflex" position is the one best tolerated if deep anesthesia or muscle relaxants are to be used; (3) when confronted with marked depression following long periods of continuous depolarization of muscle cells and when the administration of choline esterase does not restore the muscle tone, consider the need to resuscitate the muscle cells so that they may repolarize and then be able to respond to normal stimuli such as acetylcholine or epinephrine.

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COMING — THE BUREAUCRATIC SUPERSTATE ?

(The Kefauver-Celler Bill) poses a real and present danger to the drug industry, but also to the vastly greater area of freedom for American business and for Americans. If this bill becomes a model, then no area of American life is free from the threat of increasing central control, increasing bureaucratic conformity, and decreasing individual freedom. The American medical profession is also under attack. We are asked to believe that the only way to provide our senior citizens

with adequate medical care is by compulsory payroll taxes on all wage-earners, by compulsory programs of insurance, by compulsory participation in one massive, rigid, government-controlled scheme . . . What sense does such a proposal make? It makes no good sense at all, except in an America that has given up its heritage of freedom and joined the dull, drab ranks of the bureaucratic superstate.—*Richard M. Nixon to Pharmaceutical Advertising Club.*

SURGERY IN THE PSYCHIATRIC PATIENT

Carlos Triana, M.D., Hernando Ortega, M.D., *Milledgeville*

Hoke Wammock, M.D., *Augusta*

■ Experience with 838 surgical procedures performed at Milledgeville State Hospital is discussed.

“MENTAL FITNESS and physical fitness go hand in hand.” . . . Plato.

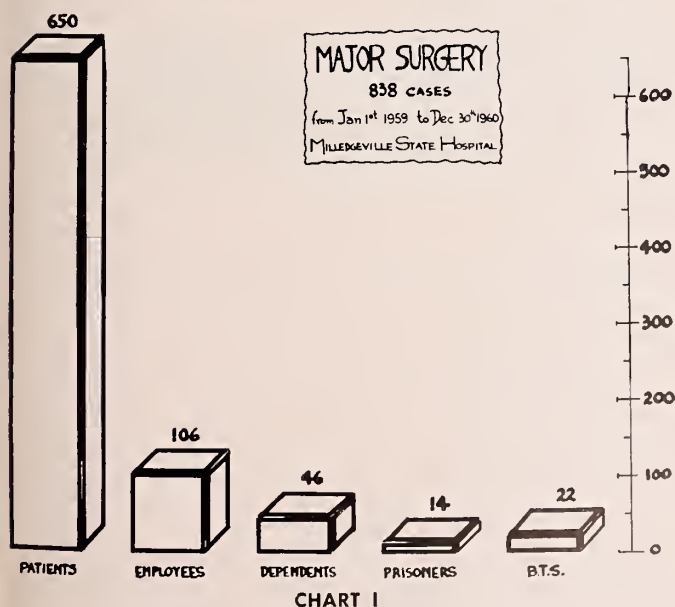
The advancement of medical science has resulted in the increase in the span of man's life. With this increase in longevity it has brought problems that are of great concern to us; these are problems of mental health and care of the aged.

Individuals with serious disturbances or judgment and social adaptability have been classified as “insane.” The word “insanity” has been replaced by the modern term “psychoses.” At the present time in the United States, the number of hospital beds for

the “insane” is approximately equal to the number of all other hospital beds combined. About one-third of all patients in mental institutions are beyond the age of 60. Many of these elderly people show signs of cerebral arteriosclerosis and senility, failing memory, and are inattentive to current events.

This is a study of 838 surgical procedures performed at the Milledgeville State Hospital during the past two years (January 1, 1959, to December 31, 1960). (Chart I) Of this number, 650 surgical procedures were performed in mentally ill patients with a mortality of 14 per cent. The remaining 188 surgical procedures were performed in hospital personnel, prisoners and inmates of the Boys Training School with a mortality rate of five per cent. The latter three categories are merely used to compare mortality figures between the mental patients and those of the general population or those in a general hospital. The remainder of this paper will deal only with the mental patients. This material was drawn from an average daily population of 11,872 patients with various types of mental disturbances, and of this number, 3,000 were over 60 years of age. The number of admissions to this hospital for 1960 was 3,772. The patients are housed in 25 buildings on the campus. Serving this colony of patients is a 350-bed hospital for acute medical and surgical problems. Thus, we are dealing with patients who have a complexity of diseases, both mental and physical.

This institution is staffed by limited professional and non-professional personnel. This limitation of



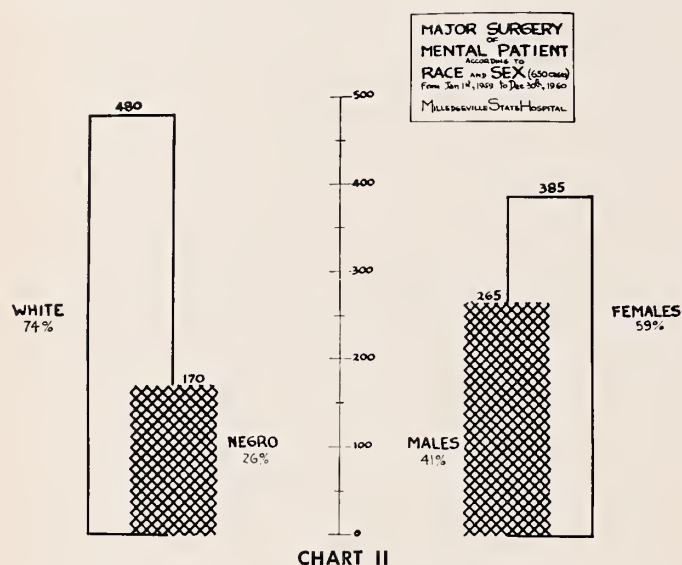
Presented at the 107th Annual Session of the Medical Association of Georgia, May 8, 1961, Atlanta, Georgia.

SURGERY / Continued

personnel is peculiar to mental institutions. It is well for us to recognize that in a general hospital there are approximately four employees to one patient, whereas in the average mental institution there is approximately one employee to every six patients.

This investigation and the work performed is shared with a consultant staff in various specialties.* The vast majority of surgical procedures with pre- and postoperative care has been performed by the two co-authors of this paper, H. O. and C. T.

The major surgery of mental patients, according to race and sex, is shown in Chart II. Seventy-four per cent were in whites, 26 per cent were in Negroes; 41 per cent were in males, and 59 per cent were in females.



Major surgery according to mental diagnosis is shown in Chart III. The largest number of cases were in those individuals with schizophrenic reaction, chronic brain syndrome, and mental deficiency. In this particular study, no attempt has been made to correlate the mental disease with the organic disease, or the type of surgery performed.

The types of major surgery performed in this group of patients include such procedures as 1) craniotomy, 2) thyroidectomy, 3) pneumonectomy, 4) mastectomy, 5) gastrectomy, 6) cholecystectomy, 7) colectomy, 8) hysterectomy, 9) commando procedures, 10) radical resections of skin lesions with graft, and 11) hip nailing.

The total surgery and total mortality according to age is shown in Chart IV. This shows the mortality for each decade. After the fifth decade, the mortality begins to rise and increases with each succeeding decade. The highest mortality occurred in the sixth, seventh, and eighth decade. This, of

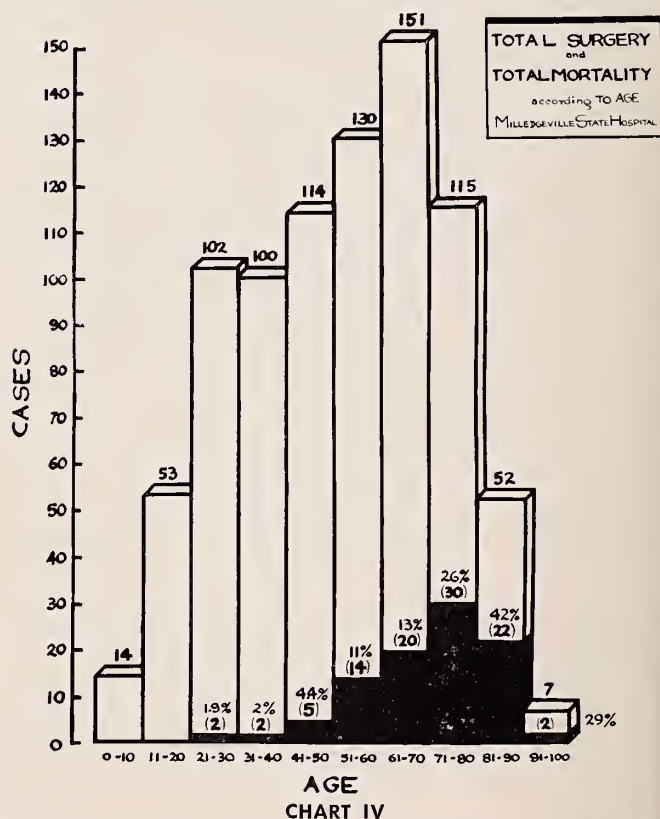
MAJOR SURGERY ACCORDING TO MENTAL DIAGNOSIS

(650 CASES) From Jan 1st, 1959 to Dec 31st, 1960

MILLEDGEVILLE STATE HOSPITAL

SCHIZOPHRENIC REACTION	129 CASES
CHRONIC BRAIN SYNDROME, ARTERIOSCLEROSIS	127 CASES
DEMENCIA PRACOX	96 CASES
MENTAL DEFICIENCY, PSYCHOTIC REACTION	82 CASES
CHRONIC BRAIN SYNDROME, SENILE	69 CASES
CHRONIC BRAIN SYNDROME, CONVULSIVE DISORDER, EPILEPSY	41 CASES
MANIC DEPRESSIVE	39 CASES
INVOLUTIONAL, PSYCHOTIC REACTION	14 CASES
DEMENCIA PARALYTICA	10 CASES
CHRONIC BRAIN SYNDROME, INFECTIOUS	8 CASES
CHRONIC BRAIN SYNDROME, TRAUMA	6 CASES
PSYCHOTIC DEPRESSIVE REACTION	6 CASES
OTHER DIAGNOSIS	23 CASES

CHART III



course, was in a group of patients that were aged, debilitated, and whose outlook on life was rather dim.

The surgical mortality of 650 mental patients is shown in Chart V. This chart follows the same pattern of increased mortality with each decade. There is a slight increase of an average of one per cent in the mental patients, in comparison to the total group including the mental and non-mental patients. In the eighth decade there is a one per cent decrease, but the number of patients is not of statistical significance.

*Dr. Milford B. Hatcher, Dr. J. Benham Stewart, Dr. Robert Rinker, Dr. William Barton, Dr. John I. Hall, Dr. Joe S. Robinson, Dr. Robert A. Clark, Jr., Dr. W. S. Flanagan, Dr. Deveraux Jarrat.

**MAJOR SURGERY
AND
MORTALITY
OF
MENTAL PATIENT**
Jan 1st, 1959 - Dec 30th, 1960
MILLEDGEVILLE STATE HOSPITAL

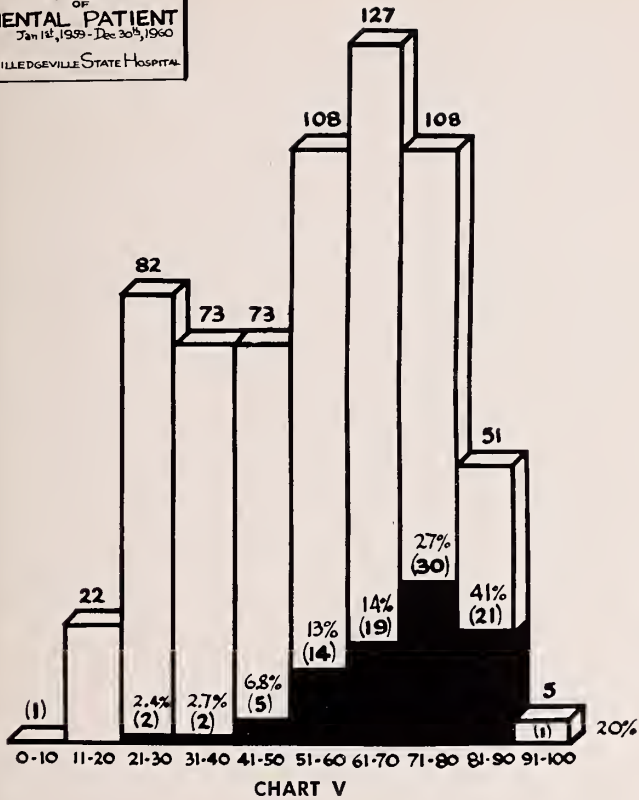


CHART V

The surgical mortality of mental patients according to surgical specialties is shown in Chart VI. The highest mortality is in the orthopedic group, with a mortality rate of 37.7 per cent. This group consists mainly of fractured hips in patients who are bed-ridden. The next highest mortality is in the gastrointestinal tract. This includes patients with intestinal obstruction, appendicitis with peritonitis, perforated viscus, and malignant disease.

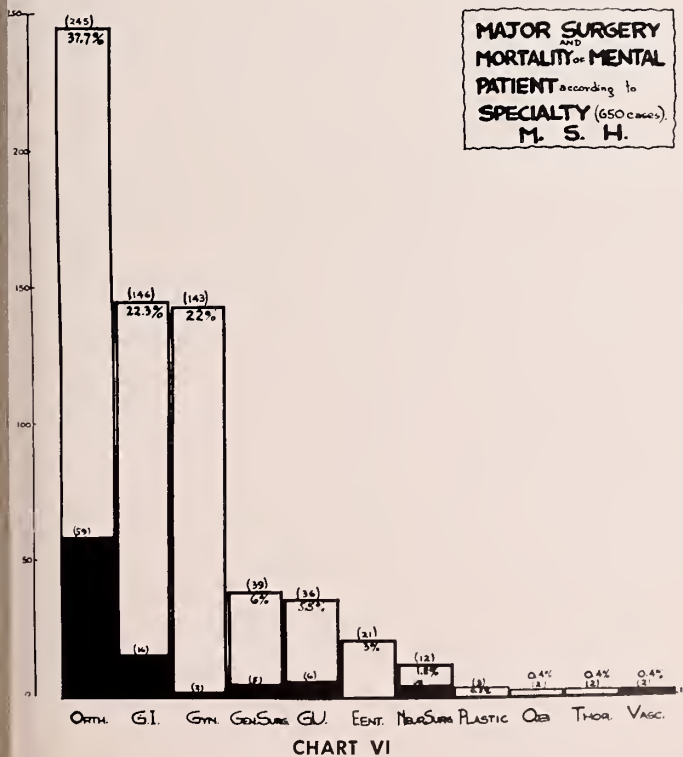


CHART VI

The mortality according to the postoperative period is shown in Chart VII. All the patients were carried through the seventh week or until they could be returned to the convalescent ward. The highest mortality occurred during the first week and then began to drop off during the second and third, with a slight rise during the fourth and fifth week.

MORTALITY

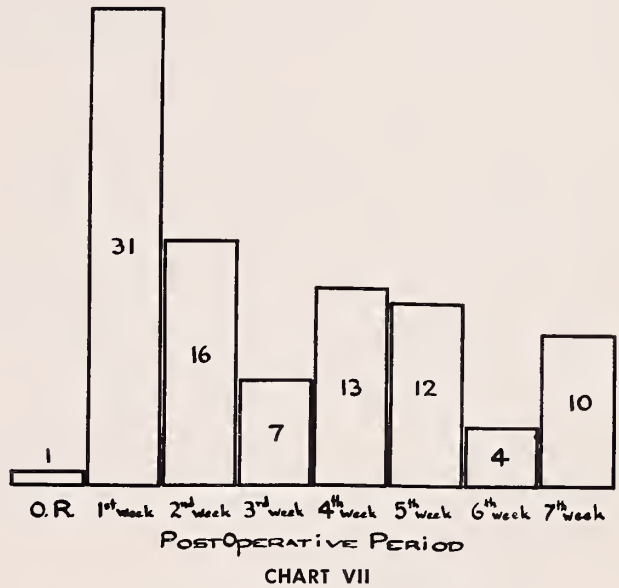


CHART VII

The surgical mortality and morbidity in mental patients is shown in Chart VIII. Good results were obtained in 65 per cent, fair results in 13 per cent, poor results in eight per cent, and a mortality of 14 per cent.

**SURGICAL MORTALITY
AND
MORBIDITY OF MENTAL
PATIENT. (650 cases).**
From Jan 1st, 1959 to Dec 30th, 1960
MILLEDGEVILLE STATE HOSPITAL

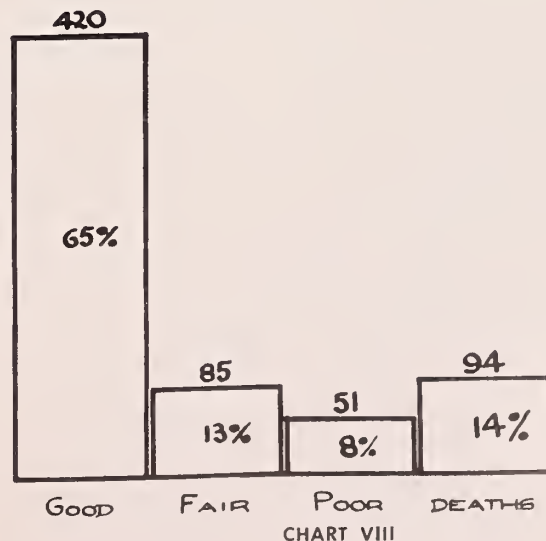


CHART VIII

The over-all mortality of 838 patients was 11.5 per cent. The mortality of all mental patients was 14 per cent, while the mortality of non-mental patients was two per cent, a rate similar to that of general hospitals.

The mortality of mental patients above 60 years of age was 25 per cent. This represents 73 per cent of the over-all mortality. Of this mortality, 33 per cent occurred during the first week of the post-operative period.

The mortality in the orthopedic cases is 24 per cent; this represents 62 per cent of the mortality in 650 mental patients.

The mortality figures in the acute fracture of the hip compare favorably with those of Manpel¹ who has reported on 469 patients with acute fracture with an operative mortality of 23 per cent and a hospital mortality of 31 per cent.

Cutler² reports acute intestinal obstruction in patients over 60 years of age as an extremely serious problem, carrying a mortality rate of 57 per cent from all causes and 47 per cent from directly related causes. The high mortality was influenced by several factors primarily related to the obstruction itself and with treatment rather than with the patient's age and his co-existing ailment.

Status of the Patient

Many of the patients are admitted with psychiatric problems, with hidden disease that may go unrecognized for an indefinite period of time. Unfortunately, the psychotic patient is unable to make known his symptoms. Some have been hospitalized for as long as 50 years. Many are physically active and others are inactive, being confined to bed. Many have no family connection, and in many the relatives are not particularly cooperative and are seemingly disinterested.

The medical and surgical hospital serving the patients of this institution receives its patients from the mental wards, with various types of mental illnesses. Some of the surgical problems are detected on physical examination by the physician, and others are observed by the attendants, while in many cases the problem goes unrecognized. A great many patients are admitted to the institution with surgical problems, and, upon correction, are dismissed and returned to society as useful citizens. There is another group of patients who suffer from a variety of psychoses which become permanent and in whom there is very little chance of mental recovery, but when the surgical problem is corrected, in a few instances, some show improvement in their mental condition.

We would like to cite a few examples of those

individuals who have had surgical complications which were corrected, and have subsequently been returned to society. One example is the individual with hyperthyroidism, cardiac decompensation, and with chronic brain syndromes who was treated with radioactive iodine later followed by thyroidectomy. His condition improved sufficiently to permit him to be dismissed from the hospital as improved. The second patient is one who attempted suicide by jumping out of a window. She had a fractured hip which was corrected, and she was dismissed as improved. The third patient, who drank Drano and had a partial gastrectomy, has been discharged from the hospital in excellent condition. The fourth patient was a case of duodenal obstruction who was mentally retarded. A gastrectomy was performed and this patient was returned to her home as a useful citizen. A fifth patient who, after going through several hospitals in this state and neighboring states, was found to have a carcinoma of the descending colon. Colectomy was performed and she was returned to her home in good condition.

Symptomatology (Subjective)

Subjective symptomatology in this group of patients is quite different from the symptomatology in patients in a general hospital or general population. With some of these patients, one is able to communicate, but even so, any information obtained is only a half-truth. There are others in whom no communication can be established, as the patient may be in an agitated or in a depressed state and is unable or unwilling to communicate. Some patients have imaginary complaints and no demonstrable pathology, while others never complain and are suffering from advanced disease. In short, it is not actually possible to obtain any reasonable or satisfactory history from most psychiatric patients.

Symptomatology (Objective)

In objective symptomatology, these symptoms are latent, and the patient usually comes in with advanced disease, and when first seen is often seriously ill with fever and abdominal distention. Patients with an acute abdomen are usually referred when they have had fever for several days, nausea and vomiting, and abdominal distention. Those who come with intestinal obstruction usually come when they have received a cathartic or several enemas for constipation without results.

Patients with strangulated hernia come when they have been vomiting for several days or with an elevated temperature. Seventy-five per cent of the patients have cardiac complications in one form or another. Chronic fibrillation is the most common type. Patients suffering with malignant diseases usually come late.

There is a group of patients who are admitted because of trauma of one type or another. Many of these are individuals with fractures of the hips and upper extremities. These patients present a problem from the standpoint of the surgical risk in the poorly prepared patients. Often patients are admitted because of having swallowed foreign bodies.

Preoperative Preparation

Because the majority of these patients who are admitted for surgery are in a poor physical condition, they are divided into two categories: those patients for elective surgery and those for emergency surgery. The necessary routine studies, such as blood count, x-ray studies, blood chemistry, electrocardiograms, and other indicated procedures, are performed as time permits, according to the degree or extent of the surgical problem at hand.

Patients for elective surgery require longer and more complete studies, including complete G.I. series, I.V. pyelograms and endoscopic studies. All these procedures are performed within the limitation of the physical facilities of the institution. The great majority of these patients are transfused pre-operatively, receive vitamin and iron supplements. The electrolyte status of the patient is determined and, in most instances when time permits, is corrected before surgery. Dehydration is one of the major problems, especially during the summer months.

Chronic bronchitis is prevalent in the majority of the older age group, especially in those who are confined to bed.

Emergency Preparation

The patient for emergency surgery is usually an immediate surgical problem. The usual routine preoperative studies cannot be performed, but those that are indicated and necessary are done expeditiously. There are times when delay in surgery is far more detrimental to the patient than trying to carry out any type of laboratory studies. The conditions of many patients with cardiac complications cannot be corrected prior to surgery because of the acuteness of the surgical problem. Patients with strangulated hernia require immediate surgery without delay because of impending gangrene, as one does not know how long ago the patient's symptoms began. Ninety per cent of all strangulated hernias need resection. Intubation in intestinal obstruction is unreliable because delay in surgery is hazardous. Any delay of surgery or prolongation of the operative procedure will naturally increase the morbidity and the mortality. Seventy-five per cent of the acutely inflamed appendices are perforated and have associated peritonitis. It is very important that the surgery be performed with rapidity in order to spare a patient from prolonged anesthesia and unneces-

sary trauma to tissue. Gentle and kindly care of the tissue is essential. Blood replacement is essential and serves to correct fluid balance and improves the nutritional status of the patient.

Types of Anesthesia

The pre-anesthetic medication is usually larger than that for the non-mentally ill patient because of their agitation. In most instances Demerol, Atropine and Phenergan are used. The type of anesthesia employed is usually Pentothal and Anectine, with associated nitrous oxide; spinal anesthesia and epidural anesthesia are also used quite often. Cyclopropane is reserved for the extremely poor-risk patients.

Postoperative Care

Postoperative care of the mental patient presents equally as baffling a problem as does the recognition and preparation of the patient for surgery and the performance of the procedure. For the administration of parenteral feedings it is necessary that a cut-down be performed for maintaining an adequate fluid intake. Indwelling catheters are used freely despite associated complications. It is necessary that every effort be exerted to maintain good hygiene because many patients are prone to soil themselves with feces and urine. Some of the factors which affect the postoperative care of these patients are:

1. Lack of cooperation on the part of the patient.
2. The patient requires closer nursing care.
3. Limited physical activity of the patient.
4. The patient requires less narcotics; his complaints are less than those of normal individuals.
5. The postoperative period is longer.
6. As aged patients do not tolerate infections very well, antibiotics are given routinely.
7. They require vitamins, iron supplement and blood.
8. Tracheostomies are indicated in any instance where it is anticipated that the patient will have obstructive respiration.

Discussion

This study of 838 patients, 650 with mental diseases of one type or another, and 188 so-called normal individuals, has provided us with much information about the complexities of surgical problems and their correction in the mentally ill patient. This group of patients presents a problem from the standpoint of diagnosis, preoperative care, surgical procedure, postoperative care, and rehabilitation. Their disease is usually advanced, they are dehydrated, in a poor state of nutrition, have a low vital capacity, and are mentally sick. The basic and fundamental care of the patient with surgical problems complicated by mental illness is essentially the same as that of the general population. Many of these psychotic

SURGERY / Continued

patients fall into the advanced-age group, and just because the patient is past 60 or mentally ill with a surgical problem, is no reason to refuse that patient the necessary surgery to correct the difficulty.

Foldes³ points out that some of the characteristics of the aged individual are those of tissue degeneration, which may or may not be replaced, and if so, it usually functions with less efficient material. The advanced age individual manifests decreased power reserve and shows increased sensitivities to such factors as lack of oxygen, fluid and electrolyte balance, trauma, infection, and the lack of essential metabolism. A great many patients in this group require emergency surgery, the need for which would have been obviated by corrective surgery at a younger age.

Today, programs for the care of the mentally ill are being expanded. Patients are receiving intensive psychiatric care, many are benefited and return to society, others will require re-admission and some will eventually become permanent patients. It is the

responsibility of the surgeon to see that the surgical problems are corrected in the mentally ill, for some of these patients may be salvaged. McDonald⁴ summarizes in his paper, "The Care of Older People":

Constant attention to apparently minor details often result in great benefit to a patient. If one cannot achieve the first objective of restoring a patient to full activity, one can still hope to recover limited activity. A forward look in attitude can bring hope and happiness to some old people; otherwise, they might sink into a bedridden or semi-bedridden state of querulous invalidism; then they are a burden, not only to themselves and their relatives, but to their community.

Medical College of Georgia

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2. Cutler, Condict W., Jr.: Acute Intestinal Obstruction in Elderly Patients. *Surg. Gyn. Obst.*, Vol. 94, 1952, p. 481.
3. Foldes, Francis F.: Preoperative Preparation and Post-operative Care of the Aged. *Geriatrics*, Vol. 7, 1952, p. 165.
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MEDICARE ANNOUNCES NEW CLAIM FORM

Effective January 1, 1961, a new Medicare Claim Form was put into use in the State Medicare Program. This form is a buff color and for use of physicians only. Different forms are used for hospital claims under the program. The old Medicare forms are to be used along with the new as long as the supplies in the physician's office last.

Basically the new form requires the same information necessary on the old form, however, the format should make completion of the form simpler. Item blocks Numbers 1 through 13 on the top half of the form must be completed by the patient, sponsor or accompanying parent of the patient. Before any payment can be made all items in this half of the claim form must be filled out completely and accurately. Generally, the patient's Medical Authorization Card (DD Form 1173) will contain all information necessary for the completion of these items. Attention given to the instructions on the reverse side of the claim form and accurate copying from the Medical Authorization Card should be sufficient to insure proper completion of the claim form.

Items Numbers 14 through 29 are concerned with the professional care rendered and should be completed by the physician concerned or his secretary. In all circumstances, however, the physician rendering the service billed for on the claim must sign the Certification in Item Number 29—rubber stamp signatures are not acceptable.

Item Number 14 on the claim form should contain

the name and address of the physician submitting the claim. The address should be the one to which the physician desires his check to be mailed. Any changes in address should be noted as such in this item number. Item Number 15 should not be completed. Item Numbers 16 through 19 are explained fully on the reverse side of the claim form. Item Number 20 should only be completed when special circumstances require its completion. Items 21 through 22 and 25 through 29 are explained on the reverse side of the claim form. Items Numbers 23 and 24 are for the use of the Medicare Office only. Special attention should be given to the Certification by the Physician in Item Number 29. Upon signing this Certification, the physician states that he will accept the payment received from the Government as full for the services rendered.

Physicians are urged to bill their charges to Medicare in relation to their normal charges for a patient with an income of \$4,500.00 a year or less. This basis of charging should be used regardless of whether or not the physician has a Medicare Manual containing the Schedule of Allowances.

Whenever possible, the physician is urged to use the procedure nomenclature contained in the Medicare Manual and the appropriate procedure code. New Medicare Manuals will be available in the near future. Requests for manuals, plus other information desired on the Medicare program, should be directed to the Medicare Department located in the Medical Association Headquarters Building in Atlanta.

SPECIAL TECHNIQUES IN TRANSFUSION

Charles M. Huguley, Jr., M.D., *Atlanta*

- ***With our increased understanding of blood clotting factors new techniques of administering blood are proving to be highly advantageous.***

BEFORE DISCUSSING special techniques of transfusion, a few general comments are in order. For the treatment of shock resulting from blood loss there is no adequate substitute for whole blood. Plasma volume expanders are used until whole blood is available. Plasma volume expanders are really substitutes for plasma and none do the job as satisfactorily as human plasma. The difficulty with human plasma in the past has been the transmission of hepatitis. This can be eliminated by using liquid plasma stored for six months at 87 to 90 degrees F. Storage at lower temperatures helps but is not as effective.

It has been recommended that when blood is used for relief of anemia the plasma should be removed first. Such patients need red cells. They usually do not need plasma, and the resulting increase in plasma volume may at times be quite dangerous. Therefore, not only is the use of cells without plasma better medicine but also we obtain a supply of liquid plasma. This can be stored in the bottle into which it is drawn for six months. It is then available for routine use as plasma. Such a procedure should provide an adequate store of plasma in each hospital to meet the routine demands.

Special handling of blood may be necessary in several situations, in which it is important to administer factors which are lost during storage. These

factors are: platelets, the antihemophilic globulin and the "labile" factor prothrombin accelerator. The administration of large amounts of bank blood to patients who are bleeding or to patients in whom extra-corporeal circulation techniques are employed will result in a dilution of these factors in the patient's blood.

In some patients with thrombocytopenia the administration of freshly prepared blood or blood products may raise the platelet count and improve the bleeding tendency. The blood must be fresh and collected in a non-wettable surface without suction. Therefore, we use a plastic bag, withdrawing by gravity. The recommended diluent is ACD solution. Sodium sequesterine has been used, but large amounts of this substance would be dangerous. ACD solution is quite satisfactory. No adequate means of preserving platelets has been devised. The blood should be administered within four hours after withdrawal. Utilizing this technique the platelet count can be raised to approximately 90 per cent of the level predicted from the platelet count of the administered blood. Such platelets will ordinarily survive for three to five days.

In acute idiopathic thrombocytopenic purpura antibodies are usually present in the blood and in such patients transfused platelets disappear rapidly. Nevertheless, the use of fresh whole blood in such patients may be of some value. In patients with chronic thrombocytopenia, such as in aplastic

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anemia, platelet transfusions may have remarkable effects, but, in general, antibodies against platelets develop so that within a few weeks most patients will no longer have a rise in platelets following transfusion. In acute leukemia, however, this has not proven to be the case, and repeated transfusions of fresh blood may be given with rise in platelets and improvement in bleeding.

In patients who need platelets but do not need red blood cells, platelet rich plasma is administered. The blood is collected in chilled plastic bags by gravity and is then immediately centrifuged under refrigeration at a low speed so as to spin down the red cells but leave the platelets in suspension. The plasma is then separated from the red cells by the use of bags especially manufactured for the purpose. The rise in platelets produced by transfusion of platelet-rich plasma is almost as good as that using blood which has not been centrifuged, and the survival is good. In the patient with acute leukemia it has been recommended that one or two donors be used who can repeatedly give blood. The platelet-rich plasma is removed and transfused into the patient, and the red cells are then given back to the donor so that he will be available for donations as often as once a week.

Platelet Transfusion

In certain situations it is necessary to raise the platelet count much higher than the relatively limited rise which can be obtained by the use of a pint of whole blood or the plasma derived therefrom. In such situations, platelet-rich plasma can be centrifuged at a more rapid speed than that used for the separation of red blood cells. The platelets are then spun down, and the platelet-free plasma is withdrawn leaving the concentrate of platelets which may represent perhaps ten cc. In this manner a patient may be given platelets from a series of donors. The recovery of platelets is not as good after this many manipulations, and the survival is not as good. Nevertheless, an excellent rise in platelets can be obtained by this technique.

Another use of fresh blood is the treatment of hemophilia. Hemophilia results from the deficiency of one of several plasma factors necessary in the early stages of clotting. About 85 per cent of patients with hemophilia have a deficiency of the factor known as AHG or antihemophilic globulin. This material disappears rapidly from blood under ordinary conditions of withdrawal. Therefore, in treating this type of hemophilia blood should be less than four hours old. If the patient is not anemic he

should not be given fresh whole blood but should be given plasma prepared from fresh blood. If the plasma is not going to be administered immediately it should be frozen and kept in the frozen state until just before use. This material is used rapidly in the body and requires replenishment every eight hours. We feel that the very minimum dosage would be the replacement of ten per cent of the normal plasma. The normal plasma volume is 40 cc. per kilogram so we use four cc. per kilogram or two cc. per pound. After this initial dose we use half as much or one cc. per pound every six to eight hours. In serious bleeding episodes we would recommend twice this much. We have found our dosage satisfactory, however.

Other Deficiencies

In the other forms of hemophilia, PTC deficiency and PTA deficiency, the missing factor is not labile and is present in bank blood or stored plasma. It is important to know the type of hemophilia present because it is easier to get bank blood or stored plasma than to get fresh blood, fresh plasma or fresh frozen plasma. Fresh materials should be used only for AHG deficiency hemophilias, and the PTC and PTA deficiency hemophilias should be treated with bank blood or stored plasma. We are rather more liberal with this than with the fresh frozen plasma. We would recommend three cc. of plasma per pound of body weight, and we would give it only once a day since the factors do not disappear from the blood as rapidly as does AHG. In preparing fresh frozen plasma it is important to use a refrigerated centrifuge.

Special derivatives of plasma are useful in certain situations.

Fibrinogen is necessary in treating the acute lack of fibrinogen which results from the presence of fibrinolysins or from the defibrination of blood by the infusion of thromboplastic substances. This syndrome occurs with amniotic fluid embolus during delivery and with abruptio placentae and may occur due to the stimulation of fibrinolysins in a variety of situations which are occasionally seen. The administration of two to four grams of fibrinogen may have a very dramatic effect. The use of plasma in large quantities may be just as effective if fibrinogen is not available.

The antihemophilic globulin is available in a concentrated and dried form. It can be used for the emergency treatment of hemophilia of the AHG deficiency variety. We do not recommend it, however, because nearly all of the patients with hemophilia who have developed antibody against the missing factor have been previously given the concentrated AHG. This situation rarely occurs when only plasma

is used in treating such patients. We, therefore, do not recommend the use of the prepared material.

As an emergency stock pile of a plasma volume expander for large scale use in a catastrophe the most satisfactory material seems to be dried albumin which has a storage life of at least five years, probably eight years and possibly much longer. Such

stock piles are being accumulated by the Federal government.

I do not feel that the use of gamma globulin needs to be mentioned other than to point out that it is a special derivative of plasma with special uses in the treatment of certain types of patients, and such material is available.

Emory University

GEORGIA PLAN FOR DISTRIBUTION OF 69 MEDICAL SELF HELP KITS

The assumption is that 69 kits will be received.

Once the program is started it should relate to either of two possibilities:

1. That additional kits are received within a reasonable time for the augmentation of the program:
 - a. We know that additional kits will not be made available to us until after July 1, 1962.
2. That the initial 69 kits constitute the total that is ever received from the Federal Government.

I Basis for Distribution

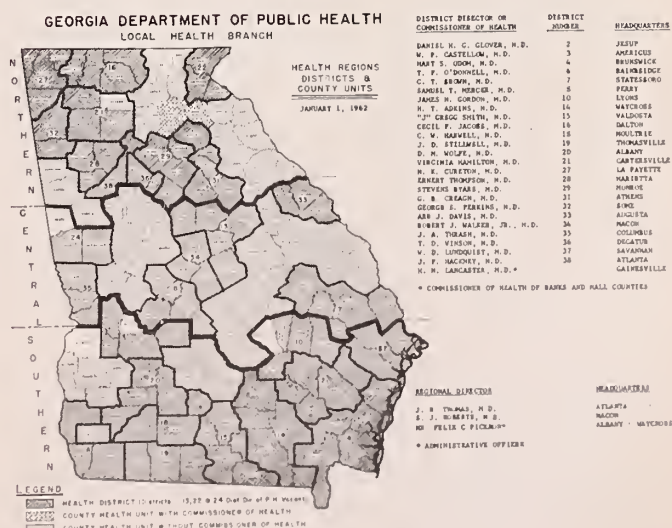
1. On a basis of population per Health District, the kits will be distributed to the District or County Health Officers of the State (see map) and they will, in cooperation with the local medical societies, school authorities, and civil directors, determine the counties, villages, or cities within their Districts where the greatest and most rapid success might be obtained in the utilization of the kits in the training of the general public.
 - a. The Department of Education will co-operate in the program by alerting the County Superintendents of Schools in the counties that lie within the Health Districts.
 - b. State Civil Defense will, through its accepted chain of command, notify all Local Civil Defense Directors of our wish to promote this particular program within the Health District of which their particular political subdivision is a part.
 - c. Appropriate publicity will be prepared and distributed at the proper time to the various information dissemination facilities within the local areas and this publicity will be so worded as to give full credit to local effort in the program.
 - d. It will be the policy of the Medical Profession, Education, and Public Health to attempt some degree of selectivity in the choice of participants in all classes in each participating community.

2. Every student taking the course during the

initial phase of the program (that period when we will have only 69 kits for the entire State) will be urged to express a willingness to serve as an instructor under medical supervision once the larger State-wide program is initiated.

- a. District Public Health Directors of the State of Georgia as well as all concerned medical, school, and civil defense authorities will be kept constantly apprised of activities within areas in which they have jurisdictional authority.

- (1) A communication will be prepared by the Civil Defense Health Services to the Regional, District and Local Health Officers of the State within whose jurisdictions it is proposed to carry on some part of the initial program. This communication will carry a brief description of the proposed program. Exact copies of the communication will be sent to Local and County Superintendents of Schools, the Medical Societies and Civil Defense Directors in the areas to be involved in the initial training effort.



DISTRIBUTION OF TOXOPLASMIN ANTIBODIES AMONG PATIENTS AT GRACEWOOD STATE SCHOOL AND HOSPITAL

N. M. Wende, Ph.D. and R. B. Dienst, Ph.D., *Augusta*

- *The higher incidence of infection among the patients working with farm animals correlated well with their degree of exposure.*

THE INCIDENCE of antibodies to *Toxoplasma gondii* in human and animal population indicates a world-wide distribution of toxoplasmosis.¹ Both man and animal may become infected with *T. gondii* congenitally or through the environment and both may present either the clinical or subclinical infection. The subclinical, or attenuated infection, occurs most frequently. Some animals, e.g. swine,² may show rapid transmission of the clinical disease within a herd, but this is unknown in human groups. However, the common method of natural transmission remains obscure in both man and animals. The rare occurrence of the acquired clinical disease in man has prevented conclusive case studies and the correlation of subclinical infection in man, his food habits,³ and his rural or urban habitation have provided no clues.⁴ Many investigators have theorized that toxoplasmosis is primarily an animal disease transmissible to man through close association.

The incidence of the attenuated infection in man varies widely from at least four per cent to 68 per cent and is usually higher in older age groups than in young children.⁵ Epidemiologic studies of variations in incidence should point to factors of transmission in the environment. Within the U.S. few survey studies have been made in the southeastern states. The following report presents data on the in-

cidence in a relatively controlled human population in the state of Georgia. This survey of the Gracewood State School and Hospital, Gracewood, Georgia, was made originally from interest in the congenital infection, which frequently results in mental retardation.

Procedure and Data

A skin test survey was made on 703 patients at Gracewood State School and Hospital. All reactors showing five mm of either erythema or induration at the site of injection after 48 hours were considered positive.

The average incidence of congenital and acquired infection was found to be 20.6 per cent overall, and 22.7 per cent for the ambulatory patients in the cottages, and six per cent for the infirmary group. Table I shows the incidence in the ambula-

TABLE I
Incidence in Ambulatory Patients by Age Intervals

Years	Number Tested	Number Positive	Per Cent Positive
9 and under	37	2	5.4
10-14	135	31	22.9
15-19	163	29	17.8
20-24	96	20	20.9
25-up	172	55	32.0
TOTAL	603	137	22.7

tory group in relation to the age of the individual. It will be noted that the young age group (one-nine

*This research supported in part by grant from National Institutes of Health, with the technical aid of J. S. Houston, M.D. (Gracewood State School and Hospital, Gracewood, Georgia), H. E. Smith, M.D. (Macon Hospital, Macon, Georgia), and H. D. Smith, M.D. (Mt. Vernon, Georgia); former students at the Medical College of Georgia. Appreciation is expressed for the cooperation of the administration staff of the Gracewood State School and Hospital.

years) shows the typically lower incidence. The incidence in the infirmary patients is presented in Table II.

TABLE II

Incidence in Infirmary Patients by Age Intervals

<i>Years</i>	<i>Number Tested</i>	<i>Number Positive</i>	<i>Per Cent Positive</i>
9 and under	23	1	4.4
10-24	64	5	7.8
25-up	13	0	0
TOTAL	100	6	6.0

Table III shows the incidence of positive skin reactors in relation to the cottages in which the ambulatory patients lived. Here cottages 10 and 28 show the highest incidence. The chi square tests, using Yates' correction, show the value of P to be less than .002 and indicates the variation is significant.

TABLE III

Incidence in Separate Cottages

<i>Cottage</i>	<i>Sex of Residents</i>	<i>Number Tested</i>	<i>Number Positive</i>	<i>Per Cent Positive</i>
18-1	F	36	2	5.5
11	M	80	8	10.0
5	M	67	8	11.9
18-2	F	29	5	17.2
23-1	M	34	6	17.6
18-4	F	40	8	20.0
12	F	98	23	23.5
18-3	F	47	12	25.5
23-2	M	49	13	26.5
18-5	F	37	10	27.0
28	M	45	23	51.2
10	M	41	21	51.2

The weighted effect, that the incidence of toxoplasmosis is greater in the older age groups, may be eliminated by comparing only the same age groups in the cottages. The data here is restricted to cottages containing a minimal number of 20 within the selected age limit and is shown in Table IV. Here cottages 10 and 28 again dominate the picture. When Yates' correction is employed the probability value is less than .013 and again indicates a significant variation.

The classical syndrome of congenital toxoplasmosis consists of chorioretinitis, cerebral calcifications, micro or macrocephaly, and seizures, although any one or combination may be absent. Congenital toxoplasmosis accounted for approximately 0.5 per

TABLE IV

Incidence in Cottages in 23 Year and Older Individuals

<i>Cottage</i>	<i>Number of 23 Year and Older Individuals Tested</i>	<i>Number Positive</i>	<i>Per Cent Positive</i>
18-5	29	7	24.2
5	24	6	25.0
12	48	17	35.4
10	20	11	55.4
28	27	18	66.7
TOTAL	148	59	39.9

cent of 1700 mentally retarded children studied by Dr. John R. Fair, Medical College of Georgia.⁶ The overall incidence of toxoplasmin antibodies at Gracewood was 19 per cent among the 47 epileptic patients and was 4.5 per cent among the 22 micro and macrocephalic patients.

Discussion

A study of the living conditions for the patients at the Gracewood State School and Hospital showed them to be under strict medical and hygienic supervision and that no unusual amount of illness of known or unknown character has been experienced in the last five years. At time of admittance each individual is given a thorough physical and psychiatric examination and is then assigned either to the infirmary (incapable of caring for self) or to a specific cottage (ambulatory). Each cottage has a relatively stable population which eats and sleeps in the same building and frequently enjoys recreation together. The cottages are located within a radius of one mile. Residents of all cottages are brought together twice a week, once on Sunday and once for a movie. Those considered capable visit their homes at varying intervals, attend public entertainments, and eat in public restaurants. The more capable individuals work in the School laundry, in the infirmary, on the farm, and on the grounds. The Gracewood School maintains a vegetable farm and beef and swine herds for food. The swine are slaughtered at the Gracewood farm but since 1960 the cattle have been sent to a commercial slaughter house for processing. Pasteurized milk is secured from a local dairy. A central kitchen prepares the food for all cottages; hospital and infirmary food is prepared separately. The members of cottages five, ten and 28 eat in the main dining room. The members of the other cottages eat in their own dining rooms. The building of new cottages, consideration of the individual's needs, return of patients to their homes, and admittance of new patients have caused members of cottages to be shifted at various times. However,

TOXOPLASMIN / Continued

the policy of the administration at Gracewood is to maintain the inhabitants in permanent groups so far as possible. Therefore, the individuals in the cottages present a select population, moderately restricted much of its life and whose cottage life corresponds to that of a loosely knit family group.

The average incidence in the ambulatory patients of toxoplasmin antibodies from both congenital and acquired infections was 22.7 per cent and thus slightly below the 29.9 per cent (standardized to census population, methylene blue dye test) found by Gibson⁷ for a rural Negro population near Memphis, Tennessee. The low incidence in the young children and higher incidence in the older age groups reflected the pattern of infection found in normal populations. It was not unexpected that the incidence of an infectious disease was quite low in the infirm patients, as most of these individuals necessarily have been restricted in their relation to the normal world.

Investigation revealed that the only related identifiable factor which differentiated the individuals with the high incidence of positive reactors in cottages 10 and 28 was that they assisted in the care and slaughter of the farm animals. Therefore a serological study (methylene blue dye test) was made of the herds maintained at the Gracewood farm. This study disclosed an incidence of 68 per cent in the swine and 83 per cent in the cattle as reported elsewhere.⁸ Thus the high incidence of toxoplasmin reactors in these two cottages was shown to be statistically associated with the high incidence of toxoplasmin antibodies in the domestic herds.

Extensive investigation has revealed no evidence of acquired clinical toxoplasmosis among either the patients or the domestic herds at the Gracewood State School and Hospital. The entire epidemiologic

picture is that of attenuated infection in which the causative organism is living in harmony, although parasitically, with its host.

Summary

The incidence of toxoplasmin reactors among 703 individuals at Gracewood State School and Hospital, Gracewood, Georgia was: overall 20.6 per cent, ambulatory patients 22.7 per cent, infirm patients six per cent, epileptic patients 19 per cent, micro or macrocephalic patients 4.5 per cent. The overall incidence was below the 29.9 per cent for a rural population in Tennessee, but showed the typical increase in incidence in the older age groups.

The high incidence of infection in the two cottages housing the patients who worked with the school's farm animals correlated with the high incidence of attenuated infection in the swine and cattle herds.

Medical College of Georgia

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HEART DISEASE MORTALITY IN GEORGIA

Heart diseases were responsible for 52.5 per cent of all deaths in Georgia during 1960, more than all other causes combined, the Georgia Heart Association recently reported.

Figures compiled by the association from the Georgia Department of Public Health indicated that 18,533 of the 35,324 deaths in the state during 1960 were caused by diseases of the heart and circulatory system.

This represents a one-year increase in heart deaths of 857 but a slightly decreased percentage rate from the 1959 figure of 52.9. Statewide heart death percentages were 53.3 in 1958, 52.8 in 1957, and 51.9 in 1956.

Dr. Clarence C. Butler, president of the Georgia Heart Association, said that the increase in Georgia heart deaths . . . which helped push the national toll

to a record 921,540 in 1960 . . . is proof enough that the cardiovascular diseases are still this country's greatest health menace.

"We must continue to support research until we have the knowledge necessary to prevent, or at least control, ALL of these diseases," Dr. Butler said. "It is true that we have made tremendous strides in overcoming some of these disorders, but we still have a long way to go. The statistics tell their own story."

He urged support of the Heart Fund as a means of furthering research. This annual February appeal has enabled the Georgia Heart Association to allocate more than \$1,000,000 for heart research since 1950. Currently, the GHA is sponsoring 16 projects in seven Georgia medical centers at an outlay of nearly \$107,000.

1962 CALENDAR OF MEETINGS

State

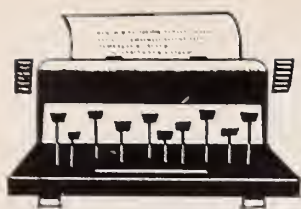
- Mar. 20-22—Pre and Postoperative Care, Medical College of Georgia, Augusta, 18 hrs. Cat. I.
- Mar. 22-24—Georgia Society of Ophthalmology and Otolaryngology, annual meeting, General Oglethorpe Hotel, Wilmington Island, Savannah.
- April 2-4—Augusta Postgraduate Medical Assembly (Coincides with practice rounds of the Masters Golf Tournament) Augusta.**
- May 6-9—Annual Session, Medical Association of Georgia.**
- June 4-9—Postgraduate course in Six Days of Cardiology, Emory University School of Medicine, Atlanta.

Regional

- Mar. 5-8—Southeastern Surgical Congress, Louisville, Ky.
- Mar. 12-15—New Orleans Graduate Medical Assembly, The Roosevelt Hotel, New Orleans.
- Mar. 16-17—Southeastern Chapter of the Society of Nuclear Medicine, annual meeting, Academy of Medicine, Atlanta, Georgia.
- Mar. 18-21—Missouri State Medical Association, St. Louis.
- Mar. 26-28—American College of Surgeons, Sectional Meeting, Hotel Peabody, Memphis, Tenn.
- April 2-6—The Gill Memorial Eye, Ear and Throat Hospital, Annual Spring Congress in Ophthalmology and Otolaryngology and Allied Specialties, Roanoke, Virginia.
- April 8-11—Tennessee State Medical Association, Peabody Hotel, Memphis, Tenn.
- April 19-21—Postgraduate Symposium in Clinical and Practical Allergy, Mound Park Hospital Foundation, Inc., St. Petersburg, Florida.
- April 23-25—Annual Meeting West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, West Virginia.
- April 26-28—Alabama, Medical Association of the State of, Tutwiler Hotel, Birmingham, Ala.
- April 29-May 2—Arkansas Medical Society, Arlington Hotel, Hot Springs, Ark.
- May 5-9—Medical Society of North Carolina 108th Annual Meeting, Sir Walter Hotel, Raleigh.
- May 7-9—Louisiana State Medical Society, Hotel Frances, Monroe, La.
- May 8-10—Mississippi State Medical Association, Hotel Heidelberg, Jackson, Miss.
- May 8-10—South Carolina Medical Association, Ocean Forest Hotel, Myrtle Beach, S. C.
- May 9-13—Florida Medical Association, Americana Hotel, Miami Beach, Bal Harbour.
- May 12-15—Texas Medical Association, Austin, Tex.

National

- Mar. 7-9—Postgraduate course in Management of Trauma, University of Colorado School of Medicine, Denver, Colorado.
- Mar. 20-23—American Association of Anatomists, Minneapolis, Minn.
- March 21-24—Neurosurgical Society of America, Buena Vista Hotel, Biloxi, Mississippi.
- March 30-April 1—American Society for the Study of Sterility, The Drake Hotel, Chicago.
- March—American Otorhinologic Society for Plastic Surgery, Philadelphia.
- April 1-6—American College of Allergists Graduate Instructional Course and 18th Annual Congress, Hotel Radisson, Minneapolis.
- April 2-14—Postgraduate course in Laryngology and Bronchoesophagology, University of Illinois College of Medicine, Chicago.
- April 2-5—American College of Obstetricians and Gynecologists, Palmer House, Chicago, Illinois.
- April 6-13—American Academy of General Practice, Las Vegas, Nev.
- April 9-12—Aerospace Medical Association, Atlantic City.
- April 9-13—American College of Physicians, Bellevue-Stratford Hotel, Philadelphia.
- April 16-18—American Association for Thoracic Surgery, Chase-Park Plaza Hotels, St. Louis.
- April 23-28—American Academy of Neurology, Statler-Hilton Hotel, New York City.
- April 30-May 2—American Academy of Pediatrics, spring meeting, Statler-Hilton, New York City.
- April 30-May 3—American Proctologic Society, Deauville Hotel, Miami Beach.
- April—American Association of Pathologists and Bacteriologists, Queen Elizabeth Hotel, Montreal, Canada.
- May 6-10—American Association of Plastic Surgeons, Hotel Del Coronado, Del Monte, Calif.
- May 28-30—American Ophthalmological Society, The Homestead, Hot Springs, Va.
- May 29-June 2—American College of Cardiology, Denver Hilton Hotel, Denver, Colo.
- June 4-22—Forty-seventh Session of the Trudeau School of Tuberculosis, Saranac Lake, New York.
- June 19-21—San Diego Symposium on Biomedical Engineering, Stardust Motel, San Diego, California.
- July 23-27—Postgraduate course in Cardiopulmonary Problems in Children, Edgewater Beach Hotel, Chicago.



MAG Encourages Scientific Exhibits

ONE OF THE MOST important highlights of the Association's Annual Session is the display of scientific exhibits made by individual physicians. There have always been from 20 to 30 of these presentations of display during the MAG four-day meeting and the profession has evidenced a great deal of interest in these exhibits. This year, as in past years, the Association encourages physician participation in this scientific activity.

The 108th Annual Session, to be convened May 6-9, 1962 at the DeSoto Hotel in Savannah, will be greatly enriched by an increase in the number of scientific exhibits. Individual physicians over the state are urged to consider sponsoring such exhibits. MAG awards attractive 1st, 2nd, 3rd place and honorable mention certificates on the basis of a scientific exhibits awards committee recommendation. Duplicate awards are presented when exhibits are comparable in the competition.

From past experience, it is known that these ex-

hibits will be viewed by the majority of doctors attending the annual meeting. With this interest by the profession, it behooves the practitioner to prepare this type of scientific exhibit in the interest of the profession. To assist the exhibitor, the Association provides ample space for the display, electrical outlets and other exhibit booth facilities. Scientific exhibits are setup by each exhibitor during a four-hour period just prior to the opening sessions which are convened at 2:00 p.m. Sunday, May 9—so that exhibitors have all Sunday morning to assemble and prepare their display. These exhibits are in a separate section, removed from the commercial exhibits, near the entrance to the scientific meeting rooms.

Physicians wishing to present scientific exhibits should request application forms from: Edgar D. Grady, M.D., Chairman; MAG Scientific Exhibits Committee; 938 Peachtree Street, N.E., Atlanta 9, Georgia.

Bone Disease of Renal Origin

THE BIZARRE CONDITION known variously as renal dwarfism, renal rickets, renal osteodystrophy, nephritogenic bone disease, etc. has been the subject of several recent studies which seem to clarify ideas about pathogenesis and treatment. The disorder is really a syndrome, for at least three distinct bone lesions are usually demonstrable in patients with advanced changes. The commonest one is *rickets* (in the child) or *osteomalacia* (in the adult) for these are synonymous terms. The adult with chronic osteomalacia has closed epiphyses, of course, but his bones are soft, radiolucent and sometimes fractured; in uncomplicated cases serum calcium is low, serum phosphorus normal and serum alkaline phosphatase concentration high. The pseudo-fractures known as Looser's lines or Milkman's disease appear in the more acute and florid examples. In the hypocalcemia which prevents bone matrix from proper calcifica-

tion and this is apparently due to increased vitamin D requirements. The disease—which is often a painful one—can be cured by vitamin D but the necessary dosage is very much higher than that required to heal the more familiar types due to diminished intake of calcium or vitamin D.

The second lesion is *osteitis fibrosa* and this is also a consequence of chronic hypocalcemia. Hypocalcemia is the important stimulus to parathyroid secretion; if sustained, it may lead to chronic hyperparathyroidism with its attendant destructive effects upon the skeleton. This disease is best looked for in x-rays of the hands which show sub-periosteal and even sub-endosteal bone resorption. If renal function is much reduced, areas of metastatic calcification may also appear, a complication which makes treatment of the coincident osteomalacia with vitamin D hazardous. It may be necessary to pre-

pare such patients by total parathyroidectomy since osteitis fibrosa is not treatable by medical means.

The third metabolic bone disease (*osteosclerosis*) is marked by focal and discrete areas of very dense bone. It is not clinically important and its origin is not understood.

The reasons for the increased vitamin D requirements seen in the first two disorders are not at all clear but there seems to be something about the uremic state which interferes with the metabolism of this sterol. There are, however, also non-uremic forms of renal disease characterized by various abnormalities in tubular transport mechanisms. Perhaps the commonest example is hypophosphatemic

or vitamin D—resistant rickets, a condition which used to be attributed to inability of the kidney to resorb filtered phosphate properly. Now, however, the negative phosphorus balance is attributed to secondary hyperparathyroidism. As in the uremic patient, the cause of this form of increased vitamin D—resistance is quite unknown but large doses of vitamin D cures the rickets. Frequent associated renal phenomena are amino-aciduria, glucosuria, hyperchloremic acidosis and the Fanconi syndrome. While it has long been customary to give alkaline salts to patients with chloride acidosis, there is little evidence that this leads to calcium retention, and vitamin D exerts its usual curative effects even in the face of continuing acidosis.

General Anesthesia Today and Yesterday

AS A SURGEON IT might be considered somewhat out of order for me to comment on the advantages of our present day anesthesia as compared with the general practices of some 20 years ago. It took World War II and the widespread use of trained anesthesiologists in military surgery to convince many surgeons that total reliance on nurse anesthetists using volatile agents left much to be desired. Non-volatile drugs for narcosis and muscle relaxation used in conjunction with volatile analgesic agents gave a type of anesthesia much superior to that previously obtained using a single volatile agent. This superior anesthesia had its drawbacks. No longer could the patients be safely handled with an ether cone, nitrous oxide tank and basic knowledge of eye signs. An adequate knowledge of physiology, more particularly respiratory physiology, was required to administer these potent, rapidly acting drugs. The necessary safety required full knowledge of the pharmacologic properties of the drugs being used. Quick and accurate decisions under stress were mandatory for maximum effectiveness. No longer could the surgeon properly supervise the anesthesia as well as conduct the operative procedure. With some reluctance he relinquished his time honored prerogative to the trained anesthesiologist. This concession has brought good results.

To detail the advantages of Surital, given with succinyl choline and small amounts of some volatile agent, is not the purpose of these comments. However, to those of us who remember the ether can in abdominal surgery, a few admissions must be made:

The induction — This is now a 30 to 40 second pleasant episode. How different it is from the fright-

ful and prolonged struggle so often obtained with the ether cone. No longer is the surgeon harassed by the moistened, rattling respirations, a grim forerunner of the atelectasis very likely to follow.

Proper oxygenation — With the endotracheal tube and artificial respirations proper oxygen exchange and tissue oxygenation give an added measure of safety in the borderline case and in the prolonged procedure.

Muscle relaxation — For the surgeons interested primarily in abdominal surgery complete muscle relaxation is an advantage difficult to appraise. The ordeal of performing a major procedure on an obese patient with poor relaxation has been relegated to the realm of memory. For those of us who were required to perform this task the memory is vivid. May it never be necessary to retrace this route. The difficult exposure with hazardous dissection and uncertain suturing were surpassed only by the problems encountered upon attempting to close the abdomen.

Smooth recovery — Though we still have patients who retch and vomit during recovery, this is the exception rather than the rule. Many patients who were last operated upon 15 or more years ago are surprised and pleased at the smooth recovery experienced now. Narcotics in the postoperative period are presently a leading cause of nausea and vomiting, no longer is ether the culprit.

The surgeon who has conceded his supervision of anesthesia, must confess that this has brought gratifying rewards. Like the horseless carriage, the anesthesiologist is here to stay. The surgeon is more than pleased to have him along.

blood pressure approaches normal more readily, more safely.... simply with **Salutensin**[®] (hydroflumethiazide, reserpine, protoveratrine A—antihypertensive formulation)

Early, efficient reduction of blood pressure. Only Salutensin combines the advantages of protoveratrine A ("the most physiologic, hemodynamic reversal of hypertension"¹) with the basic benefits of thiazide-rauwolfia therapy. The potentiating/additive effects of these agents²⁻⁸ provide increased antihypertensive control at dosage levels which reduce the incidence and severity of unwanted effects.

Salutensin combines Saluron[®] (hydroflumethiazide), a more effective 'dry weight' diuretic which produces up to 60% greater excretion of sodium than does chlorothiazide⁹; reserpine, to block excessive pressor responses and relieve anxiety; and protoveratrine A, which relieves arteriolar constriction and reduces peripheral resistance through its action on the blood pressure reflex receptors in the carotid sinus.

Added advantages for long-term or difficult patients. Salutensin will reduce blood pressure (both systolic and diastolic) to normal or near-normal levels, and maintain it there, in the great majority of cases. Patients on thiazide-rauwolfia therapy often experience further improvement when transferred to Salutensin. Further, therapy with Salutensin is both economical and convenient.

Each Salutensin tablet contains: 50 mg. Saluron[®] (hydroflumethiazide), 0.125 mg. reserpine, and 0.2 mg. protoveratrine A. See Official Package Circular for complete information on dosage, side effects and precautions.

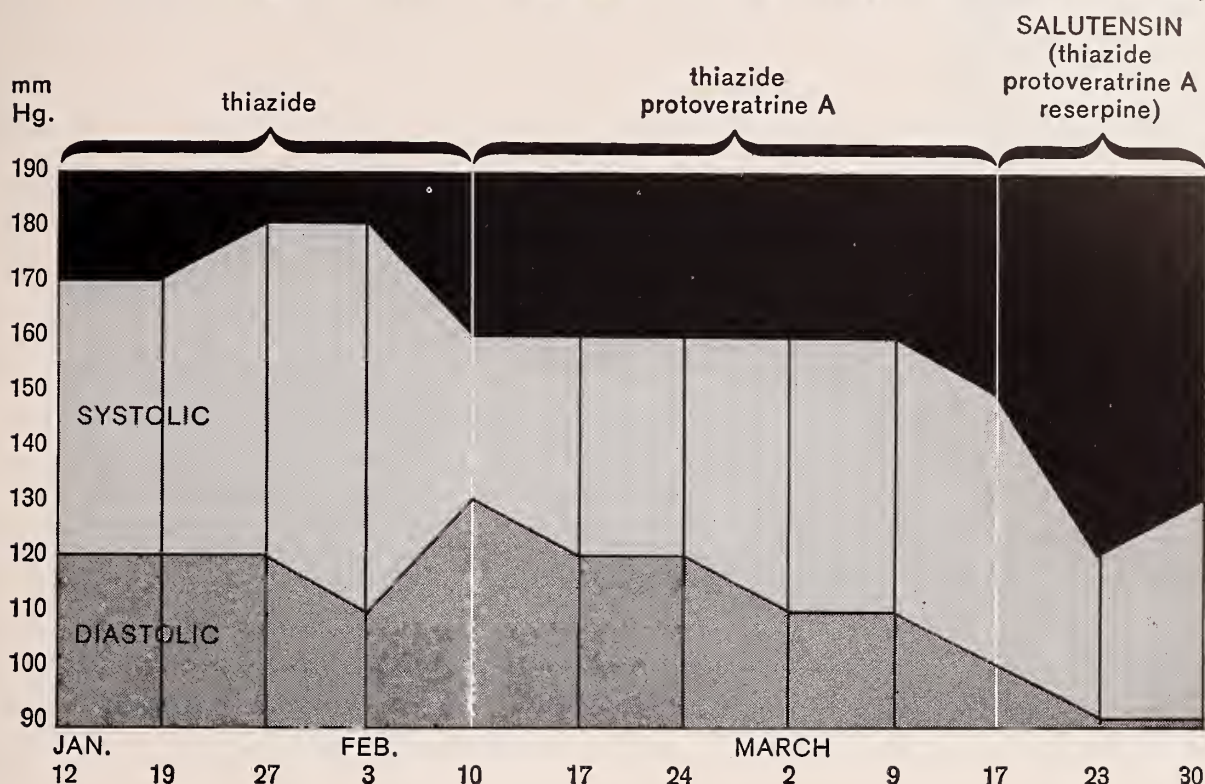
Supplied: Bottles of 60 scored tablets.

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all the antihypertensive benefits of thiazide-rauwolfia therapy plus the specific, physiologic vasodilation of protoveratrine A

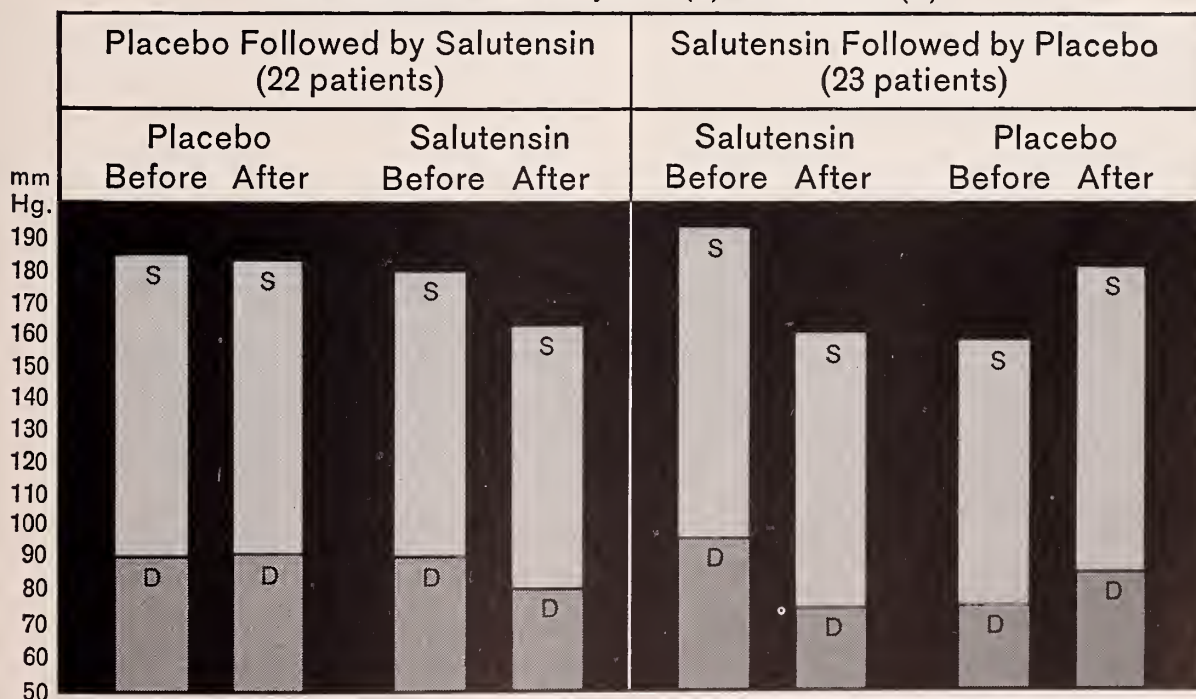
11 WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS BY SERIAL ADDITION OF THE INGREDIENTS IN SALUTENSIN IN A TEST CASE

(Adapted from Spiotta, E. J.: Report to Department of Clinical Investigation, Bristol Laboratories)



3½ WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS USING SALUTENSIN FROM THE START OF THERAPY IN A "DOUBLE BLIND" CROSSOVER STUDY

Mean Blood Pressures—Systolic (S) and Diastolic (D)



In this "double blind" crossover study of 45 patients, the mean systolic and diastolic blood pressures were essentially unchanged or rose during placebo administration, and decreased markedly during the 25 days of Salutensin therapy. (Smith, C. W.: Report to Department of Clinical Investigation, Bristol Laboratories.)

BRISTOL LABORATORIES/Div. of Bristol-Myers Co., Syracuse, N.Y.





FRED H. SIMONTON, M.D.

PRESIDENT'S LETTER

MEN AND MECHANICS

RECENTLY ANOTHER physician asked a psychiatrist why he did not treat patients for a "reasonable" fee. The intelligent answer was that when income (or fees) is concerned, it must be remembered that patients pay for the skill and time of their doctor.

The sweat and skill involved in a psychiatric interview could hardly be less than that in the performing of a tonsillectomy. But try to make the patient understand this! They are too accustomed to "seeing something" for their money, and by that something, they mean blood and tests and gadgets. This lack of understanding by the public is the real thing and it seems that only feeble attempts are being made to educate them to understand what they are paying for. The patient is not paying for a shot or a gadget but for the knowledge of when to use a shot and when not to, and what the instrument shows. Your extensive educational background and conscientious effort is what makes your time valuable. Because of lack of public education, many physicians feel it necessary to do considerable laboratory and special work simply to impress on the patient the extent of his work in order that the bill will be paid without a grumble. Even certain hospitals are charging heavily for simple laboratory procedures to carry other parts of the hospital, and this, I think, is falsely educating the public so that they think overly of the importance of these procedures and conversely less of the importance of the physician's brain. At times a physician's bill will show a smaller amount for history, physical and opinion than for

procedures, so that again, patients are wrongly educated as to what they are paying for. Should an intelligent and alert physician not needing a BMR on a patient charge less than a dull physician who needs it, or at least, takes it? How often are procedures done and the results hardly noted?

This is no tirade on the subject of fees, I think a good man deserves good fees regardless of whether he takes out a gall bladder, treats a patient with a coronary thrombosis, or treats a manic depressive psychosis but I do not think the size of the fees should be determined by the number of gadgets he used on the patient. The public should be educated to appreciate the brain first and mechanical procedures second. Your education costs many times more than an EKG but a large and potent organization says an EKG is worth \$10.00 and a cardiac examination and opinion \$5.00, and I say this does not make sense. The really dangerous part of a situation is that one begins to rely too heavily on the gadgets. They are easier to use than brains, and thus one may become slipshod in his history taking and careful examination, which after all are the two most important factors in the practice of good medicine.

A handwritten signature in dark ink that reads "Fred H. Simonton, M.D." followed by a small flourish.

President, Medical Association of Georgia



THE DIAGNOSIS OF PHEOCHROMOCYTOMA

W. D. Stribling, III, M.D., *Gainesville*

PHEOCHROMOCYTOMA is a rare tumor of the chromaffin tissues of the sympathetic nervous system. This tumor is usually located in the adrenal medulla and produces clinical symptoms by the release of epinephrine and nor-epinephrine into the blood stream. The exact incidence of this tumor is unknown, but it occurs with sufficient frequency to warrant its consideration in all patients with hypertension. It should particularly be searched for in young patients and in patients with neurofibromatosis.

The diagnosis of pheochromocytoma is established with ease in some patients and with great difficulty in others. The clinical history, response to pharmacological agents, and a direct estimation of epinephrine and nor-epinephrine in the blood and urine are usually sufficient to make a diagnosis. A wide range of clinical symptoms may be produced by this tumor. The classical paroxysmal release of hormone into the blood stream with episodic hypertension is well known. Such a tumor usually releases primarily nor-epinephrine. The epinephrine producing tumor primarily aggravates the metabolic rate often resulting in a rather marked weight loss and frequent hyperglycemia. In one fairly large series there were no obese patients found. Mixtures of the two are common with attacks of tachycardia, palpitation, headache, sweating, tremor, etc.

The use of pharmacologic agents in the diagnosis of pheochromocytoma is directed at either provoking symptoms with agents such as histamine and mecholyl, or at interrupting existing symptoms with the use of adrenergic blocking drugs such as regitine. These tests are very helpful for screening purposes but unfortunately they cannot be considered pathognomonic.

The technique of the histamine test is not difficult. This test is used primarily in patients between

attacks or in patients whose baseline pressure is below 170 mm. Hg. The patient is allowed to rest at least 15 minutes during which time a good baseline pressure is recorded. Histamine, in a dosage of 0.025 mgs. is injected rapidly intravenously into the tube of previously started intravenous infusion of five per cent glucose. The blood pressure is monitored every 30 seconds for five minutes, then every minute for approximately ten minutes. A positive test is indicated by a rise of 60 mm. Hg. in the systolic pressure or a 30 mm. Hg. rise in the diastolic pressure. Regitine or benzodioxane should be available at the bedside since serious pressure rises may occur.

The regitine test is also quite simple to perform but unfortunately false positive results are common, especially in the patient who has received such drugs as reserpine, barbiturates, etc., in the preceding 24 to 48 hours. All sedatives and antihypertensives should be omitted for at least 24 hours before such tests are done.

After a good baseline pressure has been obtained five mgs. of regitine is injected rapidly intravenously. The blood pressure is monitored every 30 seconds for three minutes, then every minute until it returns to the baseline level. A positive test is indicated by a maximum fall of 35 mm. Hg. in systolic and more than 25 mm. Hg. in diastolic pressure. This fall usually occurs quite early and the pressure rapidly returns to the baseline levels.

Probably the most reliable test for pheochromocytoma is the chemical determination of catechol amines in the blood and urine. Such tests are tricky and should be done by a trained biochemist. When properly done it now seems that most cases of pheochromocytoma which are either in a constant state of secretion or in spontaneous or provoked sudden release, will yield blood and urine

HEART PAGE / Continued

levels for catechol amines far outside the normal range. A ten to hundred fold increase in 24-hour urine content is usually attributed to pheochromocytoma when compared to normal or hypertensives.

Once the diagnosis of pheochromocytoma has been established, surgical removal should be car-

ried out and complete cure can usually be expected although the tumor is occasionally malignant. From the surgical standpoint the tumor should be localized as accurately as possible before surgery and careful pre-operative and post-operative care are necessary to control hypertension during the procedure, and the hypotension which may occur after the tumor has been removed.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association

GUIDE TO ANTICOAGULANT THERAPY AVAILABLE

The American Heart Association has just published a 30-page booklet (reprinted from *Circulation*, July 1961) containing guiding principles and practical recommendations for physicians who have decided to use anticoagulant drugs as an aid in the prevention of thrombosis or embolism.

The booklet does not describe under what circumstances or for what diseases these drugs should be employed, nor does it recommend anticoagulants by name.

Topics covered include screening of patients to make

certain that anticoagulant therapy is safe for the individual, a brief description of the mechanics of blood coagulation and a summary of the administration, action, and fate in the patient's body of the two most widely used types of anticoagulant agents (heparin and the coumarin-type drugs).

The booklet is available on request to the Georgia Heart Association, 58 Baltimore Place, N.W., Atlanta 8, Georgia.

MEDIPHONE NOW OPEN TO AID PHYSICIANS

Is there a single physician who has not been surprised and deeply concerned at some time in the middle of a dark night by the action of a drug he has given a patient? Is there a physician who has not wanted to use a drug on a critically ill patient and wished he only knew a little more about the agent? Is there a practitioner who has not wished that someone would do something to systematize the deluge of information about new developments in therapy that is overwhelming us?

The practice of medicine and, even more, drug therapy are full of surprises. As the output of pharmaceutical laboratories becomes more complex and the effects of drugs more profound in their ability to alter life's processes, the frequency of such surprises is certain to increase. Time was when a man could compound a prescription and feel quite certain of its effects. But not today.

Indeed, in the past twelve months, four widely used drugs have been taken off the market because of their unexpected, injurious effect on the patient. These were not new drugs but ones in wide use. And now they are, we find, so dangerous that they must be abandoned. There should be a still better, faster, and more systematic method of discovering such danger.

Some method of collecting data to forewarn physicians about an increasing incidence of injurious by-effects has long been needed.

Some central source to which the physician could turn for complete, objective information has long been envisioned. Such a source would give the physician

who is uncertain about the complete adequacy, reliability, and timeliness of his locally available drug knowledge a great sense of security and confidence. Such a central clearing house for drug information, professionally controlled, would fill a crying need that our leaders in medicine have long expressed.

This need is apparently to be met with a new service known as 'Mediphone'.

This is a system whereby physicians can obtain vital information about *any* drug *any* time, day or night, immediate, by telephoning the 'Mediphone' Center in Washington, D. C.

Service is available to physicians by membership. Dues are \$20 a year, deductible for income-tax purposes as a professional expense. Particularly appealing to the medical profession should be the fact that 'Mediphone' is conceived and operated by physicians. The service is personal and confidential and has no connection with advertising of any products. 'Mediphone' receives no subsidies from private industry or the Federal Government. Calls for information will be on a physician-to-physician basis and, needless to say, will not precipitate a follow-up by a detailman.

The operation of 'Mediphone' has been favorably appraised by some of the country's most respected authorities on therapeutics, medical communications, and postgraduate education.

If this exciting enterprise lives up to its promise, it will fill one of the most pressing needs of every practitioner. The advent of 'Mediphone' should be welcomed by all physicians.



PHOBIAS

Tom W. Leland, M.D., *Atlanta*

“DOCTOR, I’M SO TENSE and nervous—I’m frightened of everything.” The next time you hear this statement, you might recall some advice given non-psychiatric physicians for managing psychiatric problems: “Don’t do too much too soon.” Premature reassurance may be ineffective. Instead, ask for some examples—frightened of what in particular? In taking a detailed history of complaints of “nervousness” and “fear” the physician will often uncover phobias (the diagnosis takes only a few minutes) and in so doing, detect a curable but often incapacitating illness. Many patients who are literally confined to their homes because of a morbid fear of being alone on the open street, or unable to ride in a public conveyance, or of animals, the dark, water, etc., will present as their chief complaint “nervousness.”

Definition

The phobic patient is psychoneurotic rather than psychotic. He is readily aware of the “craziness” of his fears and hesitates to discuss his symptoms lest he be declared “insane.”

A phobia can be defined as a persistent, unreasonable fear (of object, situation, person, animal, etc.) that appears groundless or grossly exaggerated in degree. Phobias can usually be grouped according to their content into those relating to objects (e.g., morbid fear of sharp pointed objects) and those relating to situations (e.g., fear of crowded places or fear of blushing). A simpler classification is: (1) Common phobias—an exaggerated fear, reaching neurotic proportions, of those things which people universally detest or fear to some extent (e.g., snakes, spiders, illnesses) and (2) Specific phobias—fears of things that inspire no fear in the normal person (e.g., cats, open fields, escalators). Virtually any object or situation may become the object of a phobia. To classify by endowing each feared object

with an unpronounceable Greek name has fortunately become old-fashioned.

Differential Diagnosis

Two other psychoneurotic reactions are occasionally confused (and often coexist) with the phobia; namely, obsessional neurosis and anxiety reaction. In the obsessive-compulsive neurosis, there may be an obsessive fear of dying, of making a mistake, etc. These unwelcome thoughts intrude, literally force, themselves into the patient’s stream of thought and are not necessarily related to any outside stimulus. The phobia is directly related to something external to the patient’s own person, the avoidance of which serves to ward off anxiety. Differential diagnosis is important because treatment is apt to be more difficult with obsessions than with even fairly severe phobias.

The psychoneurotic person with an anxiety reaction usually suffers from a general fear of dying or from a series of nonspecific fears rather than from a fear of a specific object. The anxieties are of a free floating form, and avoidance of particular objects or situations has little direct effect. Generalized anxiety reactions sometimes develop into phobic reactions with temporary reduction of the free-floating anxiety. The phobic “solution” is rarely successful because the phobia spreads (e.g., what starts as a phobia to black cats soon spreads to a phobia of all cats and then to all four legged animals).

Pathogenesis

The phobic process begins in some situation where forbidden impulses—usually of a sexual or hostile nature—are aroused. It is fear of these impulses that generates the initial anxiety. In an attempt to ward off these forbidden impulses, the patient unconsciously displaces the anxiety to some outside

object or situation, thus converting the anxiety into something more acceptable and more manageable. This displacement is not arbitrary; there is a symbolic link between the original conflict and the feared object.

Phobias are most commonly encountered in childhood (e.g., fear of the dark). There is scarcely anyone who has not, at some time in early life, experienced fear of a phobic nature. Not all childhood phobias persists, and not all adult phobias originate in childhood.

Treatment

It is generally held that psychoanalysis and psychoanalytically oriented psychotherapy (uncovering, rather than supportive or advisory) is the treatment of choice. Few psychiatric syndromes offer a clearer indication for psychotherapy than the phobias. Treatment, to be of a curative value, consists of assisting the patient to uncover the unconscious forces creating the basic anxieties. Injudiciously timed interpretations can precipitate panic

states in phobic patients, as can attempts at symptom removal by hypnosis.

In situations where the physician is without psychiatric consultants he will do well to avoid interpretations of the unconscious conflicts, even when they appear to be obvious. A simple explanation may be in order, to the effect that the patient's phobia is not unheard of, it is not a psychosis, that it has a cause which can be detected if sufficient time and a therapist are available. Sympathetic listening and assistance in resolving current life problems may be of great help.

Prognosis

Psychotherapy offers a fairly good prognosis. Occasionally the symptoms disappear in the initial interviews, free-floating anxiety rising up to take its place. With other patients the phobia persists stubbornly until the underlying emotional conflicts are uncovered and resolved.

REFERENCES

1. The Psychiatric Bulletin, spring, 1954, pp. 36-38.
2. American Handbook of Psychiatry, Editor-S. Arieti, Vol. I. pp. 292-306; Basic Books, Inc., N.Y., 1959.

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia

CLOSED CHEST CARDIAC MASSAGE FILMS AVAILABLE

American physicians now have an opportunity to strengthen the life-saving knowledge of others who are called on for emergency first-aid treatment.

"Life in Your Hands," a film produced by Smith Kline & French Laboratories in cooperation with The Johns Hopkins Medical Institutions, explains the use of the closed chest cardiac massage technique. This new teaching aid is now available for use by physicians who conduct emergency resuscitation training programs for police, fire, industrial safety, professional lifeguard and other rescue groups with which they are affiliated.

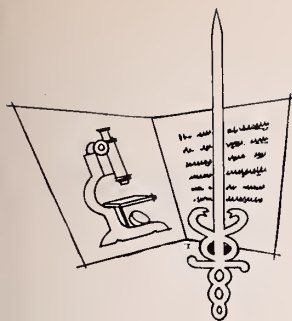
Closed chest cardiac massage, also called external cardiac massage and manual heart compression, requires no special equipment and can be used anywhere. What is needed are the rescuer's knowledge of first aid, his ability to apply direct breathing, and . . . two skilled hands.

Because closed chest cardiac massage, combined with mouth-to-nose or mouth-to-mouth breathing, must be used within three to five minutes after the heart stops to prevent damage to the brain and other organs, efforts are under way in many communities to teach the technique to members of qualified lay groups who normally arrive first at the scene of an emergency.

The current program of training adheres closely to the presentation of the technique to the medical profession for nearly a year. Already, more than 100,000 physicians have seen the initial training film, "External Cardiac Massage," produced by SK&F for medical audiences. Along with the new film for non-medical personnel, Smith Kline & French Laboratories is also supplying training manuals and leaflets as a public service for police and first-aid units, industrial safety crews, and other permanently organized rescue groups.

Prints of "Life in Your Hands," a 12-minute black-and-white film, now are available to assist other organized rescue personnel in learning this resuscitation technique. Physicians who conduct formal training programs for the members of such community rescue groups may request prints, on free loan or for purchase. Because of the need for careful supervision, prints are available only to physicians. Training leaflets also will be sent free of charge to physicians in charge of training courses when their film requests are received.

Requests for prints and literature should be addressed to: Medical Film Center, Smith Kline & French Laboratories, 1500 Spring Garden Street, Philadelphia 1, Pennsylvania.



PAIN RELIEVING DRUGS FOR ADVANCED CANCER

Thomas Harrold, M.D., *Macon*

ONE OF THE SERVICES provided for the poor people of Georgia by the American Cancer Society is the provision of pain relieving drugs when patients cannot pay for these drugs. This help is limited to a maximum of \$15.00 per month for any one person and is obtained on application through local units of the Cancer Society. These units have special arrangements with drug stores to supply drugs at reduced prices.

There are many pain relieving drugs on the market, some are much more expensive than others. Because of the limited amount of money available, the Cancer Society feels that it should be spent as economically as possible and, therefore, limits its service to a few cheapest and most effective drugs. A committee of doctors with long experience in the treatment of cancer has considered the matter most carefully and feels that more than 90 per cent of cancer patients can be as well taken care of with the following list of simple drugs as with the whole range of more expensive ones. Therefore, the Cancer Society aid is limited to these, except under unusual or special conditions.

1. Aspirin (which most patients can supply for themselves). It is surprising how much pain relief can be obtained in some patients with full doses of aspirin—up to 50 grains per day.

2. Plain A.P.C. or Empirin tablets will carry other patients for a long time.

3. A.P.C. or Empirin with varying amounts of codein, usually $\frac{1}{2}$ grain, will usually carry patients almost to the end.

4. Demoral—oral tablets have been somewhat disappointing in my experience but many doctors think that it is definitely better than codein.

5. Morphine—nothing takes the place of this old reliable. However, it should be used sparingly as patients rapidly develop tolerance for it and ask for increasing dosage at shorter intervals. It is our experience that one-sixth of a grain of morphine given every four hours gives as much relief of pain as two or three times this dose and with less side effects. To give more is wasteful and expensive. Morphine is the cheapest of all the narcotics and the most effective.

6. Tincture of Opium—Laudanum. Here is a cheap, old fashioned and very effective narcotic that has been almost forgotten in recent years. The dose is easily managed as it is given by mouth and measured with a medicine dropper. A starting dose might be five drops on a little sugar in a teaspoon. This can be given every four hours and gradually increased or varied up to ten or 15 drops according to need. It is especially useful for people of low intelligence and where no one is available to give hypodermics. It is almost as effective as morphine and is cheap. Constipation is an undesirable side effect.

Other drugs such as pantopon, dilaudid, percodan, etc., are all good but certainly no better than the ones listed above. All of them are more expensive and so at the present time only the ones listed are authorized and will be paid for by the Cancer Society.

Approved by Professional Education Committee, Georgia Division, ASC.



BOOKS RECEIVED

Freeman, Lucy, *THE ABORTIONIST*, Doubleday & Co., Garden City, N. Y., 1962, pp. 216, \$3.95.

Knickerbocker, Charles, M.D., *THE DYNASTY*, Doubleday & Co., Garden City, N. Y., 1962, pp. 416, \$4.50.

Wittenberg, Rudolph, *COMMON SENSE ABOUT PSYCHOANALYSIS*, Doubleday & Co., Garden City, N. Y., 1962, pp. 214, \$3.95.

Diamond, Edwin, *THE SCIENCE OF DREAMS*, Doubleday & Co., Garden City, N. Y., 1962, pp. 257, \$4.50.

Shepard, William P., M.D., *EXECUTIVES' HEALTH SECRETS*, The Bobbs-Merrill Co., Inc., New York, 1961, pp. 252, \$4.95.

Martin-Ibanez, Felix, M.D., *ARIEL*, M.D. Publications, New York City, 1962, pp. 280, \$6.50.

Wolstenholme, G. E. W., O'Connor, Maeve, *CIBA FOUNDATION SYMPOSIUM, SOMATIC STABILITY IN THE NEWLY BORN*, Little, Brown & Co., Boston, 1961, pp. 365, \$10.00.

Simpson, Keith, M.D., *FORENSIC MEDICINE*, Williams & Wilkins Co., Baltimore, 1961, pp. 341, \$7.50.

Hamilton, James Alexander, M.D., *POSTPARTUM PSYCHIATRIC PROBLEMS*, C. V. Mosby Co., St. Louis, 1962, pp. 144, \$6.85.

Simonson, Ernst, M.D., *DIFFERENTIATION BETWEEN NORMAL AND ABNORMAL IN ELECTROCARDIOGRAPHY*, C. V. Mosby Co., St. Louis, 1961, pp. 280, \$13.50.

Becker, Bernard, M.D. and Shaffer, Robert N., M.D., *DIAGNOSIS AND THERAPY OF THE GLAUCOMAS*, C. V. Mosby Co., St. Louis, 1961, pp. 292, \$18.00.

Katzin, Herbert M., M.D. and Wilson, Geraldine, R.N., *REHABILITATION OF A CHILD'S EYES*, C. V. Mosby Co., St. Louis, 1961, pp. 103, \$3.75.

Lisser, H., M.D. and Escamilla, Roberto F., M.D., *ATLAS OF CLINICAL ENDOCRINOLOGY*, C. V. Mosby Co., St. Louis, 1962, pp. 449, \$23.00.

Graham, John B., M.D.; Sotto, Luciano, S. J., M.D.; and Paloucek, Frank P., M.D., *CARCINOMA OF THE CERVIX*, W. B. Saunders, Philadelphia, 1962, pp. 474.

Williams, Robert H., M.D., Ed., *TEXTBOOK OF ENDOCRINOLOGY*, W. B. Saunders Co., Philadelphia, 1962, pp. 1204, \$21.00.

REVIEWS

Leider, Morris, M.D., *PRACTICAL PEDIATRIC DERMATOLOGY*, The C. V. Mosby Co., St. Louis, 1961, pp. 437, \$13.75.

DR. MORRIS LEIDER of New York University Medical School and Bellevue Hospital, has written a second edition of his volume on children's skin conditions. This book, like the first edition, is, as titled, a practical one, and has been improved mainly by the inclusion of advances in therapy which have occurred since the publication of the first volume, notably in the treatment of fungus lesions. Timely notice of griseofulvin and amphotericin B has been made, and more attention has been paid to staphylococcal infection, as would befit its new status as a difficult skin disease.

Included in the book is a 20 page formulary which covers everything any sane physician would consider advising for use in skin conditions, including tranquilizers p.o. (even though in the preface Dr. Leider makes a point of disavowing any belief in the psychosomatic etiology of skin disorders, since "without fingernails, knives, or jumps from windows, nothing they may do in their heads injures the skin especially.") The formulary is complete, with prescriptions and basic principles of skin treatment clearly outlined.

Illustrations, the backbone of a treatise on dermatology, could have been somewhat more profuse and wisely chosen (there are four pictures of alopecia for instance, none of nummular eczema), but on the whole are good and informative. They are, to the reader's as well as the author's regret, all in black and white.

The section on infantile eczema, that great Waterloo of the pediatrician, is sensible and practical and the dangers of injudicious systemic steroid therapy thoughtfully pointed out.

For a useful review of pediculosis, scabies, larva migrans, atopy, skin tuberculosis, moniliasis, nevi, acne, psoriasis, herpes, mollusum contagiosum, warts, fungus infections, and all the other skin diseases that plague the young charges of the pediatrician, this book is worthwhile reading.

Olin Shivers, M.D.

Cherniack, R. M., M.D., and Cherniack, L., M.D., *RESPIRATION IN HEALTH AND DISEASE*, W. B. Saunders Co., Philadelphia, 1961, pp. 403.

THIS IS A VERY USEFUL and timely addition to the literature on diseases of the lungs. The authors describe in understandable terms the mechanisms by which pulmonary symptoms and abnormal signs are produced. Their intention has been to bridge the gap between the technical treatises on pulmonary physiology and the purely descriptive textbooks on respiratory diseases. This they have accomplished admirably. This book should be required reading for all internists. Since respiratory diseases are so commonly seen and so poorly handled, it would be desirable for all physicians to read this book. It is remarkably well illustrated.

The reader is presented with an orderly explanation of the important types of respiratory disorder, the mechanisms of development of each type of disorder, and how such disorders produce symptoms and signs. Since traumatic disease of the chest is not neglected, general surgeons and thoracic surgeons should certainly have access to this volume. After reading this book, any physician will have a better understanding of bronchial asthma, atelectasis, lung cysts, pulmonary hypertension, pleural effusion, chronic fibrous mediastinitis, traumatic herniation of the diaphragm, cardiac insufficiency secondary to respiratory insufficiency, and numerous other problems with which we are faced so frequently.

In the opinion of this reviewer, teaching institutions should place as much emphasis on respiratory diseases as they now place on cardiovascular diseases. This volume provides a wealth of information and is highly recommended as a source of knowledge about such disorders.

Arthur M. Knight, M.D.

Rubin, Eli H., M.D. and Rubin, Morris, M.D., THORACIC DISEASES, W. B. Saunders Co., Philadelphia, pp. 968, \$25.00.

THIS BOOK REPRESENTS an excellent reference source and is truly representative of the current developments in thoracic diseases. Today exploration of the chest, including a chest x-ray, leaves much to be desired unless the person making the examination takes into consideration the functional as well as the anatomic association between the heart and the lungs. In line with this approach, emphasis is placed on the cardiopulmonary relationship. One section of the book deals with the cardiopulmonary system primarily and another with the respiratory system playing the dominant role. The chapters which involve the surgically treated lesions, and that section on thoracic emergencies, certainly contain pertinent discussions on physiological disturbances encountered here. A large section is relegated to the concepts and management of intrathoracic neoplasms. In addition, adequate space is allocated to tuberculosis, since many aspects relating to the epidemi-

ology of infectious diseases in general and to the diagnosis of pulmonary lesions center around the tubercle bacillus. This disease is still a major cause of death in many parts of the world. There is an adequate and excellent description of the treatment of this disease here. There is also a very representative section on thoracic diseases in the young, and this book should be of considerable help to the pediatrician and obstetrician who see intrathoracic anomalies in infancy. In addition the internist has to be acquainted with the incipient stages of such lesions. A very good explanation is given of the so called "man made" syndromes which are recognized for the first time. The iatrogenic aspect of disease in the chest is certainly a worthwhile one to be familiar with. The concluding section deals with the principles of diagnosis and particularly emphasizes the importance of taking a complete history. This is an excellent section which should be of help to all of those interested in the diagnosis and management of chest disease.

This book will have a place as an authoritative reference for all those interested in the diagnosis and management of chest diseases. It is a text which is essentially new in its concept, and insofar as its scope and completeness is concerned. It should prove a splendid reference source and one to be placed in the category of Cecil's Textbook of Medicine and Anderson's text of Pathology.

Robert H. Vaughan, M.D.

HISTORY OF THE OLD MEDICAL COLLEGE

The Augusta Council of Garden Clubs has published a history of the Old Medical College in booklet form. This booklet is dedicated to Mrs. Rodney S. Cohen—"whose vision that this historic building would be restored as a cultural monument to Augusta's past and be preserved as a cultural center for Augusta's future. This has been brought to fulfillment by her selfless dedication and infectious zeal which inspired others."

Excerpts from this very worthwhile booklet follow:

The Old Medical College stands today as one of our most beautiful and venerable buildings. It is pure in its architecture, imposing in its simplicity, rich in its history. This noble building stands as a monument worthy of preservation. It will still be beautiful a hundred years from now, for it belongs to a period that has never wearied and a style that has never been surpassed.

In 1808 a call was sent out inviting all physicians of Augusta to gather for the purpose of founding a medical association; but it was not until 1822 that the Medical Society of Augusta was incorporated. Dr. Milton A. Antony, in collaboration with his pupil Dr. Joseph A. Eve operated a school of medicine in connection with the City Hospital, but the school had no authority to confer degrees—the young men "read medicine."

An Act of December 20, 1828, established and incorporated the Medical Academy of Georgia, and graduates were allowed to practice medicine and surgery as fully as if licensed by the State Board.

In December, 1833, the name was changed, this time to the Medical College of Georgia, and the Board of Trustees of the Richmond Academy granted to the

Medical College 140 feet at the west end of the Academy lot fronting on Telfair Street and running south to Walker Street. The deed stated "that the grounds so granted shall never be sold or conveyed to any person or persons and never used . . . by it for any other purpose." It further provided therein that the building and grounds should revert to the Trustees of the Richmond Academy whenever it ceased to be a medical college.

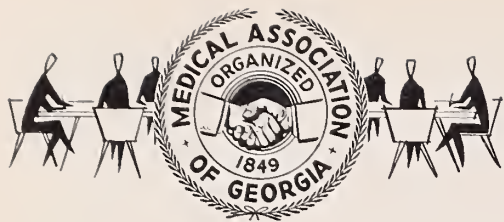
From 1926 to 1931 this venerable old building was left to the ravages of time, it suffered the deterioration of an unused building, weeds grew rank in the surrounding yard. The dedicated members of the Sand Hills Garden Club, with a consecrated reverence for the old and beautiful, undertook the restoration of the building. They had many plans—A Memorial Auditorium. A Museum, certainly a place for flower shows, music and meetings. In 1935, when the "Old Medical College" celebrated its 100th birthday, their dreams and plans were fast becoming a reality.

In 1948 the Old Medical College became the home of The Augusta Council of Garden Clubs, Inc. Today, 1962 there are 38 Garden Clubs, with their many activities and civic projects, that have made our City a place of beauty.

This spacious old building lends itself to weddings, receptions, teas, luncheons, and meetings of civic and social organizations.

The building is open to visitors:

9:00 A.M. to 5:00 P.M. Monday through Friday
9:00 A.M. to 1:00 P.M. on Saturday



THE ASSOCIATION

DEATHS

SALMON A. KOFF, 56, of Atlanta died December 18, 1961. Dr. Koff was the founder and director of the Koff Psychiatric Clinic in Atlanta.

He was a graduate of the University of Illinois Medical School and did his internship at Franciscan Willard Hospital in Chicago and residency at E. Moline State Hospital in E. Moline, Illinois.

Dr. Koff was associate professor of clinical psychiatry at Emory University, chairman of the psychology department of Atlanta University, attending psychiatrist at Grady Hospital, consulting psychiatrist to the Atlanta Federation of Jewish Social Service, the Atlanta Jewish Home and the Child Service Association of Atlanta. He was a member of The Temple, the American Medical Association, the Fulton County Medical Society and the American Psychiatric Association.

He is survived by his widow, Belle Tomarkin Koff; a daughter, Mrs. Sherwyn Syna of Atlanta; a son, Lonny Koff of Atlanta; his mother, Mrs. Minnie Koff of Chicago; sisters, Mrs. Charles Grossman and Mrs. M. S. Meyer of Chicago, and a brother, Robert Koff of Chicago.

T. LUTHER BYRD of Atlanta died at the age of 68 on December 19, 1961.

Dr. Byrd was a graduate of the University of South Carolina and the University of Georgia Medical School. He served as an interne at the University Hospital in Augusta. He did postgraduate work in internal medicine at Johns Hopkins University. He was one of the founders of the Good Samaritan Clinic in Atlanta, a charter member of the Atlanta Clinical Society, a member of the Diabetic Society and had served as president, secretary and treasurer of the American Association of Medical Milk Commission. Dr. Byrd was a member of the Fulton County Medical Society, the American Medical Association, the Southern Medical Association and Second-Ponce de Leon Baptist Church.

He is survived by his widow, Lillian Smith Byrd; sons, Thomas L. Byrd, Jr., and Milton Daniel Byrd of Atlanta; and a sister, Mrs. Carol Williams of Griffin.

EMILE OTTO SCHARNITZKY, 72, of Augusta died December 22, 1961 after a brief illness.

He was a graduate of Richmond Academy and Birmingham Medical College of Alabama in 1915. He served for several years as county physician. Dr. Scharnitzky was a member of the American Legion, the Forty and eight of the Legion and of the Lutheran Church of the Resurrection. He was a member of the Richmond County Medical Society, the Medical Association of Georgia and the American Medical Association.

Dr. Scharnitzky is survived by his widow, Margaret Triplet Scharnitzky; a son, Emile O. Scharnitzky, Jr.,

of Newton, Ala.; a daughter, Mrs. Joanne S. Snowden of Atlanta; and six grandchildren.

WILLIAM CHARLES WANSKER, Atlanta Thoracic surgeon, died December 31, 1961 at the age of 38.

He was a graduate of Duke University and Duke University School of Medicine. Dr. Wansker did postgraduate work in Winston-Salem, N.C.; Chattanooga, Tenn.; and the Veteran's Hospital in Atlanta. He was an instructor in surgery at Emory University School of Medicine.

Dr. Wansker was a member of the Fulton County Medical Society, the Medical Association of Georgia, the American Medical Association, the American College of Surgeons, the American and Georgian Thoracic Societies, the American Heart Association, the American Association for Thoracic Surgery and the Atlanta Tuberculosis Association. He was a member of St. Martin-in-the-Fields Episcopal Church.

Survivors include his widow, Dorothy Hall Wansker; a daughter, Janice L. Wansker; a son, William R. Wansker; his parents, Mr. and Mrs. Joseph Wansker of Atlanta; and two brothers, Robert L. Wansker of Atlanta and Bernard A. Wansker, M.D. of Charlotte, N.C.

CHARLES S. FLOYD, 79, of Loganville died on January 1, 1962. He had served the people of Walton County over 50 years.

He was a graduate of State Normal School and completed Atlanta Medical College in 1909.

Dr. Floyd was a charter member of the Walton County Medical Society of which he served as president. He was also a member of the American Medical Association and the Medical Association of Georgia. He was a member of the Lawrenceville Presbyterian Church. Dr. Floyd served on the staff of Governors Eugene Talmadge and Herman Talmadge.

He is survived by his widow, Pearl McGarity Floyd and a brother Aaron B. Floyd of Atlanta.

PERSONALS

First District

HERBERT D. SMITH of Mount Vernon has recently been assigned to the United States Army Hospital at Fort Stewart as a Medical Officer.

W. W. HILLIS, JR., formerly of Sardis has moved his practice to Millen. He maintains an office in the Mulkey Hospital.

JULES VICTOR, JR. of Savannah has been named president of the staff of Memorial Hospital. Serving with him are FRANKLYN P. BOUSQUET, JR., president-elect and J. J. DOOLAN, JR., secretary-treasurer.

WALTER R. VOYLES of Waynesboro has been named a member of the American College of Surgeons.

Second District

E. M. FLOWERS of Tifton was recently named chairman of the Tifton City Commission.

CLARENCE E. BRIDGER of Albany returned recently from a three-day session of the southeastern regional American College of Pathology at Bowman Gray School of Medicine, Winston-Salem, N. C.

Third District

JAY GOLDSTEIN of Warner Robins was named in January as chairman for the 1962 Heart Fund Drive in Houston County.

CHARLES COWART of LaGrange recently spoke to the LaGrange High School on the causes and symptoms of cancer.

Fourth District

E. RAYMOND LEVERETT, formerly of Rutledge, has joined W. C. TIPPINS, JR. of Hogansville in the practice of medicine.

THE FOURTH DISTRICT MEDICAL SOCIETY met in January and elected the following officers for 1962: Norman Gardner, president; Robert Foster, vice-president; and Morgan Kellum, secretary-treasurer.

Fifth District

PAUL TURRENTINE of Atlanta spoke recently to the Savannah Exchange Club on the "Future Effect of Atomic Fallout."

R. M. MARTIN, JR. of Conyers recently accepted an appointment as Regional Medical Director of the U. S. Civil Service Commission for the seven South-eastern states, Puerto Rico and the Virgin Islands.

ELEANOR B. PETRIE was recently appointed medical director, nutrition section, Georgia Department of Public Health.

TOM LELAND of Atlanta is the visiting physician at the newly founded Mental Health Clinic at Athens General Hospital. His hours are from 1:30-4:30 on Wednesdays.

Sixth District

JOSEPH BOHORFOUSCH of Milledgeville spoke to the Women's Auxiliary to the Baldwin County Medical Society in January on "The Problems of Aging."

WILLIAM E. POUND was named in January by the Macon City Council to serve as city physician in the new annexation area.

WILLIAM L. BARTON of Macon has been elected president of the medical staff at Parkview Hospital. Serving with him are ROBERT E. CATO, vice-president and W. O. WILLIAMS, secretary-treasurer.

THE SIXTH DISTRICT MEDICAL SOCIETY met at the YMCA in Macon recently and heard Dr. Will C. Sealy of Duke University, Dr. Charles M. Huguley Jr. of Emory University and Dr. Curtis G. Hames of Claxton speak.

JULE C. NEAL, JR. has recently been named chief of the medical staff at Macon Hospital for 1962. Other staff officers include: W. L. BARTON, vice chief-of-staff; J. L. KING, SR., president of the staff; SAM E. PATTON, vice-president of the staff; and WILLIAM H. SOMERS, secretary-treasurer.

Seventh District

HARVEY HOWELL of Cartersville spoke to the

local Rotarians in January about his practice over the years.

BYRON H. STEELE of Fairmont was elected chief of the Gordon County Hospital medical staff at a recent meeting. Other officers include: WILLIAM R. THOMPSON, vice chief of staff and R. D. WALTER, secretary.

Eighth District

ROBERT SMITH of Waycross spoke in January to the local Rotarians on "War Against Cancer."

E. R. JENNINGS of Brunswick spoke in January to the local Kiwanis Club. The subject of his talk was on the lack of interest in health matters.

OLLIE O. MCGAHEE, JR., of Jesup is on a two year tour of duty with the U. S. Army Medical Corps. He is stationed at Fort Polk, Louisiana.

E. A. DANEMAN of Waycross was elected a fellow of the American College of Physicians recently.

J. T. NUNALLY III and DAN B. ELROD of Hazlehurst have moved into new offices on the Douglas Road.

Ninth District

A. A. ROGERS, SR. of Commerce was honored in January by a tribute in Jefferson's *Jackson Herald*.

JAMES D. SCHULER of Ellijay has recently returned from the Southern Medical Convention in Dallas, Texas.

Tenth District

C. H. DICKENS of Madison has been named Chief of Staff at Morgan Memorial Hospital. Selected as vice chairman was CLYDE MCGEARY, JR. and L. K. LEWIS as secretary.

SOCIETIES

BALDWIN COUNTY MEDICAL SOCIETY had a paper on "Cardiac Freaks" presented to them in January by Dr. Tom Ross of Macon.

BLUE RIDGE TRI-COUNTY MEDICAL SOCIETY met the last of January and elected the following officers for 1962: President, H. E. Mitzelfelt; Secretary-Treasurer, Thomas J. Hicks.

CAMDEN-CHARLTON COUNTY MEDICAL SOCIETY met at the home of Dr. and Mrs. Al Bauknecht for their January meeting. Dr. Max Porrier, pedodontist from Jacksonville, was the guest speaker.

CARROLL - DOUGLAS - HARALSON COUNTY MEDICAL SOCIETY had Dr. R. D. Allen present a case history of an elderly female with diverticulitis of the colon with obstruction at their January meeting.

CHEROKEE MEDICAL SOCIETY recently elected the new officers of the R. T. Jones Memorial Hospital. They are: Robert Tyre Jones, president; Arthur Hendrix, vice-president; and Ben K. Looper, secretary-treasurer.

CRAWFORD W. LONG MEDICAL SOCIETY recently elected new officers for 1962. They are: John M. Wilkins, president; John D. Elder, vice-president; and George Erwin, secretary-treasurer.

EMANUEL COUNTY MEDICAL SOCIETY elected new officers in January for 1962. They are: R. G. Brown, president; R. J. Moye, vice-president; and H. W. Smith, secretary-treasurer.

FULTON COUNTY MEDICAL SOCIETY installed

their 1962 officers at their annual banquet in January. They are: Tully T. Blalock, president; R. Carter Davis, president-elect; J. Willis Hurst, vice-president; and Thomas J. Anderson, Jr., secretary-treasurer.

GEORGIA MEDICAL SOCIETY had as a guest in January, Dr. Henry K. Beecher, Dorr Professor of Anesthesia Research at Harvard Medical School and Head of the Department of Anesthesia at Massachusetts General Hospital. He spoke on "Various Factors Surrounding Diseases and Treatment of Diseases."

GORDON COUNTY MEDICAL SOCIETY elected their 1962 officers recently. They are: Charles K. Richards, president; William R. Thompson, vice-president; and R. D. Walter, secretary-treasurer.

SOUTHWEST GEORGIA MEDICAL SOCIETY recently elected their 1962 officers. They are: Turner W. Rentz, president; W. H. Hall, vice-president; and R. E. Jennings, secretary-treasurer.

SPALDING COUNTY MEDICAL SOCIETY elected their 1962 officers recently. They include: H. A. Foster, president; Grady Black, vice-president; and Ira Slade, Jr., secretary-treasurer.

EXECUTIVE COMMITTEE OF COUNCIL MEETING

THE REGULAR MONTHLY MEETING of the Executive Committee of Council was called to order at 3:35 p.m. by Chairman Fred H. Simonton, at MAG Headquarters Building, Atlanta.

Those attending the meeting were Fred H. Simonton, Chickamauga; George H. Alexander, Forsyth; Milford B. Hatcher, Macon; and John T. Mauldin, Atlanta. Also present were MAG Attorneys Mr. Francis Shackelford and Mr. John Moore, and staff members Mr. Milton D. Krueger, Mr. James M. Moffett and Mrs. Catherine Wooten.

AMA Legislative Conference, Jan. 26-27

Mr. Moffett stated that another representative of MAG could attend the AMA Legislative Conference due to the fact that J. Frank Walker would be attending as a member of the AMA Council on Legislative Activities. It was recommended that MAG President-Elect Thomas W. Goodwin attend if possible, in addition to Fred Simonton, John T. Mauldin and Mr. Moffett, who had previously been designated. Dr. Simonton was asked to contact Dr. Goodwin regarding his attendance.

Meriwether Memorial Hospital Problem

Mr. Shackelford stated that a "friend of the court" brief will be filed by MAG attorneys.

Hospital Housekeeping Supervisor's Program

Chairman of Council Alexander had been asked by Council to designate a member of MAG as liaison on the advisory committee before a decision can be made by MAG regarding the endorsement of the program outlined by Dr. Hatcher at the December Council meeting. Dr. Alexander, in consultation with Dr. Hatcher, recommended Charles H. Richardson, Sr., Macon. On motion duly made and seconded it was voted to approve the appointment of Dr. Richardson to this position and to so notify him of his appointment.

Interprofessional Council Appointment

Due to resignation of a member of MAG on the Interprofessional Council, it was requested that a replacement be ap-

pointed. Dr. A. H. Letton, Atlanta, was recommended as a replacement. On motion duly made and seconded it was voted to submit Dr. Letton's name as a replacement on the Interprofessional Council.

Raiford Letter

Mr. Krueger read a letter from Dr. Morgan Raiford addressed to Dr. Hatcher regarding investigation of cases in the Welfare Department. On motion (Mauldin-Hatcher) it was voted to write Dr. Raiford to gather data on the subject matter and forward it to MAG so that it can be referred to the proper Board.

AMA Council on Medical Education and Hospitals

Mr. Krueger read a letter from Leland S. McKittrick, Chairman of the AMA Council on Medical Education and Hospitals, asking that two representatives from MAG be designated to attend a meeting of this Council on February 3, 1962, in Chicago. On motion (Mauldin-Hatcher) it was voted to designate Walter Bloom, Atlanta, if he is agreeable to attend this meeting; and to ask the Georgia Academy of General Practice if they wish to send a representative at their expense.

Date and Site of February Executive Committee Meeting

February 18, 1962, 2:30 p.m., MAG Headquarters, Atlanta.

Date and Site of March Council Meeting

March 17-18, 1962, Atlanta.

County Medical Society Officers Conference

Mr. Krueger reported on the tentative plans for this meeting February 17-18, 1962, Dinkler Hotel, Atlanta.

Warner Robins Hospital Problem

This problem was discussed by Dr. Hatcher and Dr. Mauldin stated the matter would be investigated by the Georgia Hospital-Medical Council at an early date.

Medical Assistance to the Aged Program

Medical Director Mauldin gave a progress report on the program, which officially began operation on January 1, 1962.

There being no further business the meeting was adjourned at 4:40 p.m.

SPECIAL CALLED MEETING OF EXECUTIVE COMMITTEE OF COUNCIL

THE SPECIAL CALLED MEETING of the Executive Committee of Council was called to order at 2:35 p.m. at the MAG Headquarters Building, Atlanta, by Chairman Fred H. Simonton.

The invocation was given by Dr. Hatcher.

The members of the Executive Committee attending were Fred H. Simonton, Chickamauga; George H. Alexander, Forsyth; J. G. McDaniel, Atlanta; Milford B. Hatcher, Macon; and John T. Mauldin, Atlanta. Guests attending were J. Frank Walker, Atlanta; and MAG Attorneys Mr. Francis Shackelford and Mr. John Moore. MAG Staff members present were Mr. Milton D. Krueger, Mr. James M. Moffett and Mrs. Catherine Wooten.

Recodification of Georgia Health Laws

Chairman Simonton opened the discussion on the "cost of care" provision in the Family Responsibility Chapter of the recodification of Georgia health laws (88-801)) which will be presented to the 1962 Legislature for adoption, and which matter has caused controversy between MAG and the State Board of Health. He explained the proposal by the State Board of Health, which amended the proposal submitted by the Medical Association of Georgia. There was general discussion about the subject and disapproval was voiced by the Executive Committee.

Mr. Shackelford proposed a letter for Executive Committee consideration, in answer to the State Board of Health amended proposal, which is as follows:

The State Board of Health
John H. Venable, M.D., Director
Georgia Department of Public Health
47 Trinity Avenue, S.W.
Atlanta 3, Georgia

Gentlemen:

As you will recall, representatives of this Association and of the Department met on December 27, 1961. At that time this Association proposed an arrangement which we earnestly felt would be practical for the Department while not violating the ethics of the medical profession in the handling of collections for cost of care at State institutions under the control of your Department.

We have received a proposal by the State Board of Health adopted at its December 28 meeting. It changes the wording of Chapter 88-8 of the proposed Health Code by inserting the phrase "reimbursement of cost of care" in place of "cost of care." In addition, it places control of the disposition of funds received under the Chapter in the State Board of Health rather than in the Director. Lastly, language would be added stating in effect that, while the Department proposes to render professional services and collect fees for them through its employees, this shall not constitute the practice of a profession.

After carefully studying your proposal, we strongly feel that it would establish third party practice of medicine as to pay patients. Such a program would violate the ethics of the medical profession and we have no choice but to oppose its enactment.

The House of Delegates of The American Medical Association in June, 1956, adopted the following resolutions:

"(It is) the policy of The American Medical Association that funds received from the private practice of medicine by salaried members of the clinical faculty of the medical school or hospital should not accrue to the general budget of the institution and that the initial disposition of fees for medical service from paying patients should be under the direct control of the doctor or doctors rendering the service."

"Nothing in this Report is meant to condone the corporate practice of medicine or policies which result in the diver-

sion of physicians' fees to a corporation or governmental agency."

The Constitution and By-Laws of the Medical Association of Georgia as amended adopt the principles of medical ethics of The American Medical Association as the principles of ethics of The Medical Association of Georgia.

The Supreme Court of Georgia, in *Boykin v. Hopkins*, 174 Ga. 511, 162 S.E. 796 (1932) at 174 Ga. 522:

"The Bar, which is an institution of the highest usefulness and standing, would be degraded if even the humblest member became subject to the orders of a money-making corporation engaged, not in conducting litigation for others. The degradation of the bar is an injury to the State. A corporation can neither practice law nor hire lawyers to carry on the business of practicing law for it, any more than it can practice medicine or dentistry by hiring doctors or dentists to act for it."

The Medical Association of Georgia strongly supports the Department of Public Health in its efforts to strengthen legislation on Family Responsibility. We sincerely believe it possible to solve this problem ethically and practically, either through our proposal of December 27, 1961, describing the kind of program now successfully employed at the Eugene Talmadge Memorial Hospital, or through some other method which would not violate Medicine's traditional opposition to third party practice in connection with pay patients. The Medical Association of Georgia, through its officers and attorneys, renews its offer to work with you and your attorneys in a vigorous effort to solve this question. With a constructive approach by all parties we are confident that a good solution would be found.

Very truly yours,

THE MEDICAL ASSOCIATION OF
GEORGIA

FRED H. SIMONTON, M.D., *President*

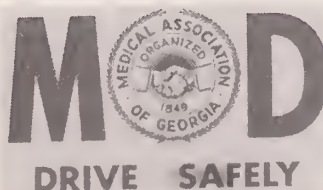
On motion (McDaniel-Alexander) it was voted to approve the letter as read and to send it to Dr. Venable and the members of the State Board of Health, over the President's signature.

There being no further business the meeting was adjourned at 3:30 p.m.

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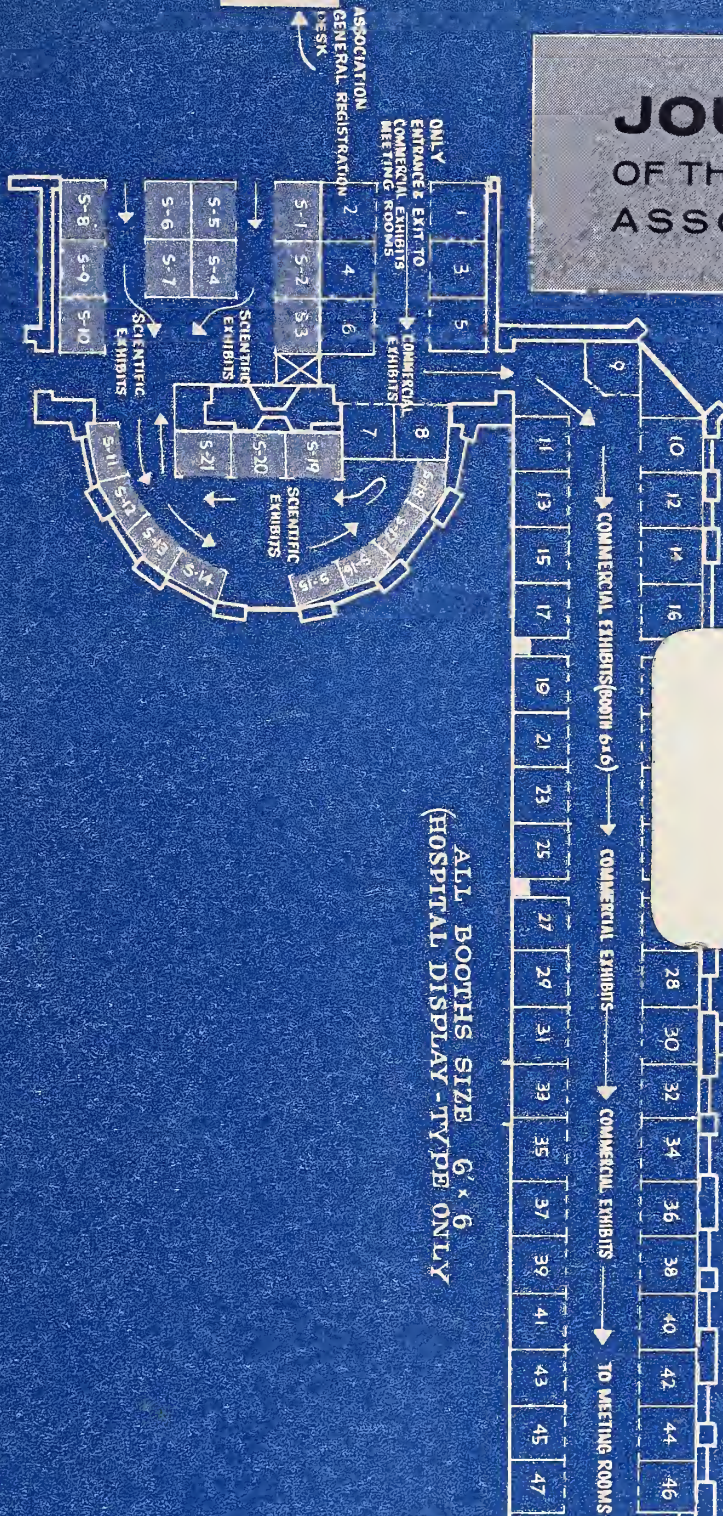
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PROGRAM ISSUE

See Page 110





**when the perfect combination
is threatened by a cough...**



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THE TOXICITY OF LOCAL ANESTHETIC DRUGS

Charles R. Allen, M.D., *Galveston, Texas*

■ *The reaction of ciliated epithelium to local anesthetic agents has provided a dependable and uniform method for experimental testing*

IN 1884 KARL KOLLER demonstrated the local anesthetic properties of cocaine. During the succeeding 77 years hundreds of drugs have been subjected to pharmacologic study and clinical trial in the quest for better regional anesthetic agents. Only a few have withstood the tests of time and are in general use today. In order to survive for clinical usage, a new local anesthetic must not only be potent and capable of consistently producing nerve block of satisfactory duration but it must have a low toxicity. Undesirable reactions to local anesthetic drugs may be divided according to local damage to the tissues, allergic reactions and systemic reactions with predominant effects upon the cardiovascular and nervous system.

Local damage to the tissues is most apt to occur when new local anesthetic drugs are released for clinical practice without sufficient evaluation of their toxic effects upon human tissues. There may be pain on injection, marked local inflammatory reaction or even sloughing of tissues. A more serious complication may follow injection in the proximity of nerves where neuritis or irreversible changes in the nervous and perineural tissues may develop. Sometimes the local tissue injury is due not to the anesthetic agent itself but rather to intense vasoconstriction following the inclusion of vasopressors to prolong the duration of the block.

Allergic reactions to local anesthetics have occurred in patients who have had one or more previous exposures to a drug.¹ It is apparently an antigen-

antibody response and may manifest itself in the form of skin rashes, urticaria, laryngeal edema and bronchospasm. The onset of this type of reaction may not occur for several hours or days following the use of the offending drug.

Circulatory Effects

Irrespective of the manner by which a local anesthetic agent is administered, it eventually passes into the vascular system. Most of the difficulties which arise from the use of these drugs are due to systemic intoxication caused by an excessive amount of the anesthetic in the blood stream. The symptoms which develop, their severity and their duration depend upon the blood level, the rapidity by which it is attained, the amount of drug which perfuses the susceptible organ and the individual toxicity of the drug itself. The lower the blood level necessary to precipitate an untoward response, the more toxic the drug. It should be emphasized that the blood level depends largely upon the rate of absorption of a drug from the injection site and the rate of clearance from the blood stream. These two factors make it of the utmost importance that we establish precautionary measures in our injection technique and in the selection of proper anesthetic drugs for clinical use.

When drugs of this type enter the circulation they depress the conductivity, contractility and irritability of the heart and may even produce cardiac arrest. Arterial hypotension may develop as the result of direct myocardial depression or a peripheral action causing vasodilation or the combined effect of cardiac and peripheral depression. Cardiovascular

¹Presented at the 107th Annual Session of the Medical Association of Georgia, May 7, 1961, Atlanta, Georgia.

reactions of this type occur in patients with myocardial disease when regional blocks are performed with quantities of local anesthetics normally used in healthy adults. Local anesthesia is frequently chosen for operations on "poor risk" patients on the erroneous assumption that it is better tolerated than other forms.²

Neurologic Effects

Responses of the central nervous system indicate that initially there is stimulation followed by depression. Excitement, apprehension, disorientation, nausea and vomiting may occur within a few minutes following the administration of a local anesthetic drug. If the personality of the patient is such as to lead the physician to suspect that these manifestations are indicative of hysteria he may be rudely awakened to the realization of their true significance when convulsive seizures ensue. As the initial phase of stimulation fades into the phase of depression, coma, loss of reflexes, and respiratory and circulatory failure develop. The initial phase of stimulation will seldom last more than a few minutes and may be antagonized by central nervous system depressants. Barbiturates have been employed for this purpose for many years and are effective in the control of the more minor reactions; however, for optimum effect the barbiturate must be injected immediately. Only the ultra short-acting drugs should be administered and these in only minimum amounts lest they compound the depression phase of the anesthetic which follows the phase of stimulation. Once the depression phase has been reached, barbiturates are contraindicated. They are incapable of neutralizing the local anesthetic, inactivating it or hastening its detoxification.² Adequate ventilation with oxygen and support to the circulation with intravenous fluids, peripheral vasoconstrictors and myocardial stimulants should be instituted.

Toxic Effects

The protective action afforded by the prophylactic administration of 100 mg. of Nembutal or Seconal is probably of very little value if the blood concentration of the local anesthetic agent reaches convulsion strength. It is of interest to check back to the original reference work upon which this clinical practice was established. The use of barbiturates in the treatment of patients manifesting signs of acute intoxication from overdosage by local anesthetic drugs is based upon two articles written by Tatum and co-workers and published in 1925³ and 1926.⁴

The 1925 report indicated that the MLD of cocaine for the dog is about 27 mg. per kilogram

when administered subcutaneously. By the administration of a mixture of sodium barbital in paraldehyde, dogs were able to survive cocaine dosages up to 100 mg. per kilogram. The dosage of the protective mixture, however, was 100 mg. of sodium barbital per kilogram dissolved in five cc. of a saturated solution of paraldehyde dissolved in saline solution per kilogram. The MLD of cocaine for rabbits was found to be 100 mg. per kilogram. If a dosage of 200 mg. of sodium barbital per kilogram was injected intravenously the MLD was raised to 150 mg. of cocaine per kilogram. It was interesting to note that if the barbiturate was not given to the rabbits but artificial respiration instituted instead, then the MLD was raised to 350 mg. of cocaine per kilogram. The report published in 1926 indicated that a dosage of 70 mg. of sodium barbital per kilogram in 3.5 cc. of the paraldehyde solution per kilogram would protect against injections of cocaine in dosages from 40 to 100 mg. per kilogram. From this information can you calculate the dosage of barbiturate which would protect a human from convulsions of local anesthetic intoxication?

It is virtually impossible to correlate the vast accumulation of data from many laboratories concerning the potency and toxicity of local anesthetic drugs. This is primarily caused by the great diversity of experimental animals and methods employed to obtain the data.

Assay Methods

In searching for more sensitive and more objective methods for the comparison of local anesthetic agents we decided to utilize tissue culture techniques and to expose cultured human tissue to various local anesthetics in order to observe the effect of these drugs on cell activity. Ciliated epithelium appeared to be the most valuable for such cytotoxic studies since the ciliary beat could easily serve as an index of cellular response.

Proetz and Pfingsten described a method for cultivating ciliated nasal mucosa of the guinea pig fetus in 1936 and 1939.^{5,6} Ten years later a tissue culture study of human ciliated nasal epithelium was reported by Rose, Pomerat and Danes.⁷ In 1956 successful cultivation of human tracheal and bronchial epithelium was performed in the Tissue Culture Laboratory of the Medical Branch in Galveston. When electrolyte balance and other physiological factors such as osmotic equilibrium are present cultures of human respiratory epithelium maintain a steady state for 15 to 20 hours. Increased strength or rapidity of ciliary beat or disturbance of coordination of ciliary motion following exposure of the cells to the drugs under study may be interpreted as a cytotoxic effect of the local anesthetic agent. The

observation of such tissue with phase-contrast photomicrography and, particularly, with cinematography seemed to offer ideal conditions for observing and recording the results of such investigations.

The following information is from the reports of work done by Dr. Gunter Corssen of the Department of Anesthesiology in collaboration with the Tissue Culture Laboratory at the University of Texas Medical Branch, Galveston.^{8,9}

During general anesthesia, tissue was obtained from the tracheal and bronchial mucosa of man by means of a small caliber biopsy punch without the use of local medication. These biopsies were placed in Gey's balanced salt solution (BSS) immediately after removal from the trachea or bronchus. In the course of this study 2059 explants from 119 different patients were cultured and examined.

Ciliary action ceased immediately after transferring the tissue into the test tube with Gey's balanced salt solution but was seen to begin again within six to eight hours after being embedded in a plasma clot. It reached maximum activity within two to three days and was kept from ten to 12 days. Usually the outgrowth of an epithelial sheet from the explanted tissue began with the reactivation of ciliary motion. Frequently such sheets showed a tendency to lose their continuity so that pieces of epithelial tissue of various sizes became free. The edges of these epithelial fragments often curled to form little globes or balls which rotated by means of their actively beating cilia. As soon as such rotating globes appeared the whole explant was transferred into a perfusion chamber equipped with an inlet and an outflow tube. After thoroughly sealing the cover glass carrying the explant to the roof of the chamber Gey's balanced salt solution at room temperature was perfused through the system. This did not disturb the activity of the rotating spheres. Local anesthetic solutions to be perfused through the chamber were prepared by dissolving the crystals of each drug in Gey's BSS. The effect on the ciliary action was observed with either phase-contrast, time lapse cinematography at a rate of four frames per minute, or by scanning at a rate of 16 frames per second.

The type of response of the epithelial globe following exposure to the various local anesthetic agents at different concentrations is believed to represent the toxic effect on the cell. An increase of ciliary action appears to be the result of a stimulatory effect which can persist for a measurable length of time, or may only be a transient phenomenon. A depressant action results in a decrease of ciliary activity resulting in the slowing of rotary speed and finally stoppage of this activity. The depressant action is either reversible or irreversible.

This method was used for a comparative study of procaine, chlorprocaine, lidocaine, cocaine, tetracaine and dibucaine. For each of these local anesthetics the concentration was determined which (a) did not affect ciliary activity, (b) caused persistent stimulation, (c) resulted in initial stimulation with subsequent decrease of activity, (d) stopped ciliary action, but with re-perfusion with BSS resulted in revival of the tissue and (e) arrested ciliary action with permanent cell injury and re-perfusion with BSS failed to reactivate ciliary beat.

The low toxicity and the remarkable broad spectrum of effectiveness of procaine, chlorprocaine and lidocaine upon the cultured cell was significant. All three drugs failed to produce permanent injury at clinically useful concentrations. Tetracaine and dibucaine revealed a considerably higher toxicity to the cells. The margin of activity without causing permanent cell damage was observed to be considerably smaller and cellular activity was rendered irreversible at concentrations commonly used in producing regional anesthesia in man. Cocaine appeared to occupy a position between the procaine-chlorprocaine-lidocaine and the tetracaine-dibucaine groups.

Conclusions

I firmly believe that this method of testing has merit. It will be of especial value when we wish to compare the depressant effects of new drugs with those previously observed and with related drugs already accepted for clinical use.

800 Mechanic Street

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FUNCTIONAL OBSTRUCTION OF THE VESICAL NECK IN ADULTS

J. W. Morgan, M.D. and Charles Eberhart, M.D., *Atlanta*

■ *This condition is thought to result from a congenital defect of the opening mechanism of the vesical outlet.*

FUNCTIONAL OBSTRUCTION of the vesical neck is herein defined as an abnormal resistance (obstruction) at the vesical outlet induced by a failure of the internal vesical orifice of the bladder to open properly during micturition wherein the vesical neck and urethra are anatomically normal. It is of congenital origin.^{1,2} Being congenital it becomes manifest as symptoms at an age according to the magnitude of the defect. Its onset in adults is insidious, it waxes and wanes symptomatically and it easily escapes the attention of patient and physician. Our experiences with it dictates its routine consideration in adults with urinary tract problems.

Davis² implies that infravesical obstruction is prevalent in adults but attributes it to a variety of possible factors, one of which is the calibre of the urethra. Recent contributions by Woodburne³ and Lapidès⁴ aid in comprehension of the dynamics of micturition. They state that the vesical outlet during micturition is opened by active contraction of the longitudinal muscle in the proximal urethra and the longitudinal muscle radiating about the internal vesical orifice of the bladder. A concept of the normal and abnormal forces responsible for functional obstruction is shown diagrammatically in Figure 1.

The recognition of this obstruction depends upon an evaluation of symptomatology, voiding rate, and retrograde cystography.

Symptomatology

These patients have never voided normally and for this reason rarely volunteer symptoms of obstruction. Men, being relatively immune to complicating infection, may have bizarre symptoms.⁵ Women are exceedingly susceptible to com-

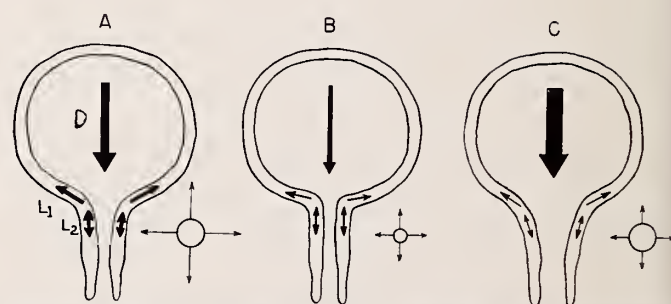


FIGURE 1. Illustrates concept of forces occurring during micturition. D = Detrusor force of bladder. L₁ and L₂ indicates direction and magnitude of force produced by longitudinal muscle of bladder and urethra respectively. A. Normal. B. Functional obstruction. Detrusor, L₁ and L₂ forces of decreased magnitude resulting in obstruction at vesical outlet and impairing voiding rate. C. Functional obstruction. Detrusor force greatly increased and although L₁ and L₂ are of decreased magnitude, urine escapes at normal rate in spite of deterrent force at vesical outlet.

plicating infection. The following symptoms should cause one to suspect functional obstruction: troublesome childhood enuresis, an ability to retain urine for long intervals, mal-odorous urine, an episode of urinary retention, post-delivery or post-operative urinary retention, chronic or acute cystitis, cystitis with fever, infected renal calculus in absence of obvious related obstruction and a history of nephrectomy for reasons other than neoplasm.

Voiding Rate

A determination of the voiding rate⁶ for an optimum void on two or more occasions may establish positive evidence of obstruction. A simple office test consists of filling the bladder per catheter with irrigating fluid to a moderate or strong desire to void (optimum capacity) and then timing the void (optimum rate) with a stop watch. By dividing the elapsed time into the volume of the void, the voiding rate in milliliters per second can be determined. A voiding rate of one to nine ml per second is classed as

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severe obstruction. Drake⁷ found the normal voiding rate of adults to be 20 ml per second for a minimum void of 200 ml. Paradoxically, obstruction may exist though the voiding rate be normal or very high. A persistently impaired voiding rate suggests a failing detrusor force while a high rate suggests a detrusor force capable of delivering urine at a rapid rate in spite of the deterrent force at the vesical outlet. Consequently, the test may be deceptive.

Retrograde Cystography

This procedure is performed routinely in conjunction with diagnostic cystoscopy and pyelography in the hospitalized patient. Under heavy intravenous sodium pentothal sedation, the bladder is filled per catheter under gravity to a hydrostatic pressure of 20 cm above the vesical neck employing a 2½ per cent sodium iodide solution. The capacity thus determined is considered to be the maximum bladder capacity. Films are exposed upon completion of the fill, after a ten minute delay and during micturition upon removal of the catheter. This study permits two important observations; the most frequently important being the maximum bladder capacity. The normal capacity is 300 to 500 ml. When psychic inhibitory impulses are allayed the bladder capacity in the afflicted individual often exceeds the optimum capacity by 50, 75 or 100 per cent. Cystography may demonstrate a less frequent complication of obstruction but one of greater importance, namely vesicoureteral reflux.

The above studies usually establish two or three definite indications for treatment. In patients having mild symptoms such as infrequent cystitis, mild or moderate impairment of voiding rate, mild to moderate alterations in maximum bladder capacity, and a normal upper urinary tract, palliative treatment is employed. Dilatation of the urethra may give temporary relief although the voiding rates of these individuals cannot be demonstrated as improved. For those having persistent symptoms and upper tract complications open operation seems to assure the greatest degree of success. When our findings justify operative intervention, we favor a modification of the Young "V" plasty operation⁸ or revision of the vesical neck as shown in Figure 2.

The following cases are cited briefly to illustrate the various aspects of diagnosis and results of treatment.

Illustrative Cases

Case 1. A 14 year old male had his initial attack of acute pyelonephritis in April 1958 with prompt response to chemotherapy, and a second attack on 13 April 1959. Otherwise, the most significant history was that of being able to delay micturition for

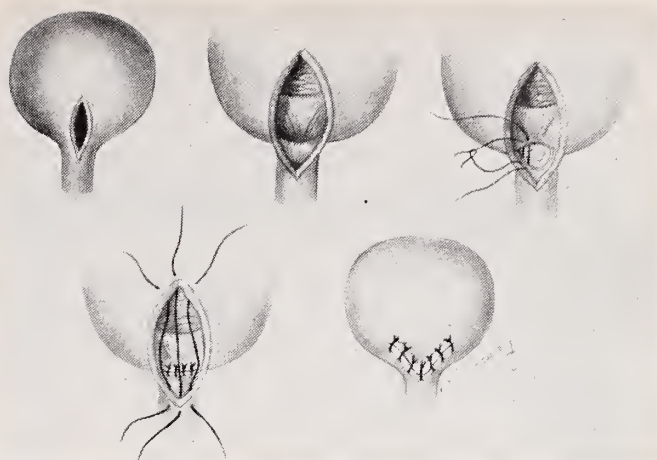


FIGURE 2. Illustrates steps in modified Young V Plasty operation.

six to eight hours. There were no obstructive symptoms. He voided a large forceful urinary stream. Childhood enuresis had ceased at two years of age. Examination revealed right flank tenderness, a normal prostate gland and pyuria. A void of 360 ml was accomplished, with obvious straining, at a rate of 30 ml per second. An intravenous urogram revealed a normal upper urinary tract except for complete bilateral reduplication of the ureters. He was hospitalized on April 22, 1959 and cystography revealed the maximum bladder capacity to be 1000 ml. Figure 3. Vesicoureteral reflux could not be



FIGURE 3. Case 1. Cystogram, on left showing bladder of twice normal capacity found on initial examination resulting from vesical neck obstruction. Cystogram, right, made 12 months after vesical neck revision with return to normal capacity.

demonstrated. No obstructive lesion could be seen at the vesical neck. A vesical neck revision was performed on the following day. The vesical neck was found to be elastic, of normal calibre, and pathologic examination of the wedge of tissue taken from the vesical neck was normal. Follow-up cystography on June 8, 1960 revealed the capacity to be 350 ml. On March 30, 1961 the voiding rate for a void of 350 ml, without straining was 27 ml per second and a urinalysis revealed an occasional pus cell and numerous bacteria. He has been asymptomatic for the two year follow-up period.

Comment

The two important features of this case are the two episodes of pyelonephritis and the abnormal bladder capacity. Although vesicoureteral reflux could not be demonstrated, the renal infections are considered to have been induced by it. The abnormal bladder capacity is indicative of a decompensating bladder and is thought to result from obstruction. The normal voiding rate on the initial examination was accomplished by straining and was deceptive. The bladder capacity returned to normal in one year.

Case 2. A 36 year old married female gave a history of enuresis until eight years of age. Two episodes of cystitis, right flank pain, and fever had occurred at 18 years of age. Urinary retention was present for two days following two pregnancies and a laparotomy. During the fourth month of pregnancy in 1956, she had right ureteral colic and passed a calculus spontaneously. Following laparotomy in February 1959, she had cystitis, chills and fever, and right flank pain for four weeks. She was hospitalized in March, June and August 1959 with a urologic diagnosis of acute pyelonephritis. Each attack subsided in three days on Kantrex and Chloromycetin. The urologist reported evidence of a chronic right pyelonephritis and a normal left kidney on intravenous urography. He discharged her on Kynex.

We first saw the patient on August 24, 1959. She complained of malaise, mild right flank pain and nocturia times ten. Upon close questioning she stated that she had always had difficulty in voiding and that sometimes a strong desire to micturate disappeared on the way to the commode. Sometimes two voids were required to obtain a sensation of emptiness. Occasionally, following an abortive attempt to void, she experienced pain characteristic of right regurgitate ureteral colic. On examination, a mild pyuria was found. When the bladder was filled with irrigating fluid, she voided 300 ml at a rate of 11 ml per second with 350 ml residual. Endoscopy was negative for abnormality of the vesical neck and ureteral orifices. Retrograde cystography was positive for right vesicoureteral reflux. (Figure 4). The maximum bladder capacity was 850 ml. Retrograde pyelography confirmed the previous finding of chronic pyelonephritis of the right kidney and a normal left kidney. Urine culture was positive for *E. Coli*.

A vesical neck "V" plasty operation was performed September 1, 1959. The internal vesical

orifice was normally elastic and normal in calibre. Pathologic study of a wedge of tissue taken from the internal vesical orifice revealed no marked variation from normal.

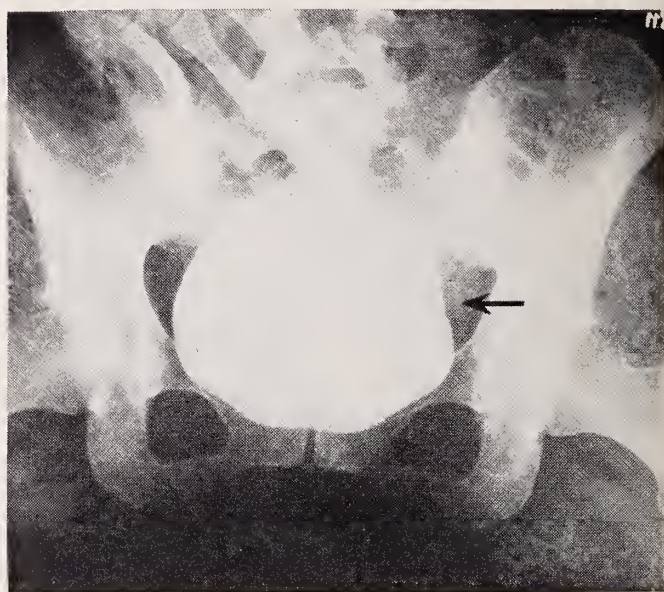


FIGURE 4. Case 2. Cystogram showing faint amount of contrast media in lower right ureter representing vesicoureteral reflux.

Postoperatively the urine became microscopically negative in three months with chemotherapy. At this time the voiding rate was 21 ml per second for a void of 800 ml and residual urine was absent. On September 28, 1960 cystography revealed a maximum bladder capacity of 800 ml without vesicoureteral reflux. Two small renal calculi which had not previously been noted were seen in the right kidney area. Urine culture was negative.

When last examined 19 months after operation she reported occasional mild frequency and dysuria but had no further attacks of urinary tract infection. The urine was microscopically negative. The optimum voiding rate for an optimum void of 600 ml was 18 ml per second. No residual urine was present.

Comment

The findings in this patient demonstrate the three important diagnostic features of infravesical obstruction. The symptomatology is life long in duration. The voiding rate was impaired, confirming the history. The cystogram also sustained the history and explained the course of events. The prolonged vesical outlet obstruction ultimately led to vesicoureteral reflux which induced repeated attacks of right pyelonephritis with secondary stone formation.

Summary

In summarizing, functional vesical neck obstruction is thought to result from a congenital defect

of the opening mechanism of the vesical outlet. The important features of diagnosis have been presented. In our hands, open operation in the form of a vesical neck revision assures the greatest degree of success.

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MEDICAL DISASTER PLANS

The Civil Defense Operational Survival Plan, as adopted by the State of Georgia, states that all counties will draft a disaster plan applicable to their own community. This plan should include, among other essentials, provision for a sorting station away from the local hospital, preferably in a school or warehouse, under the direction of the most experienced local physician available. The use of schools, warehouses, churches, and other public buildings, the establishment of holding stations and outpatient care centers, the use of police, firemen, and other auxiliary personnel, the potential use of stored civil defense emergency hospitals, the use of trucks for ambulances with provisions for training the drivers in first aid, the sources and flow of supplies, should be included in the plan.

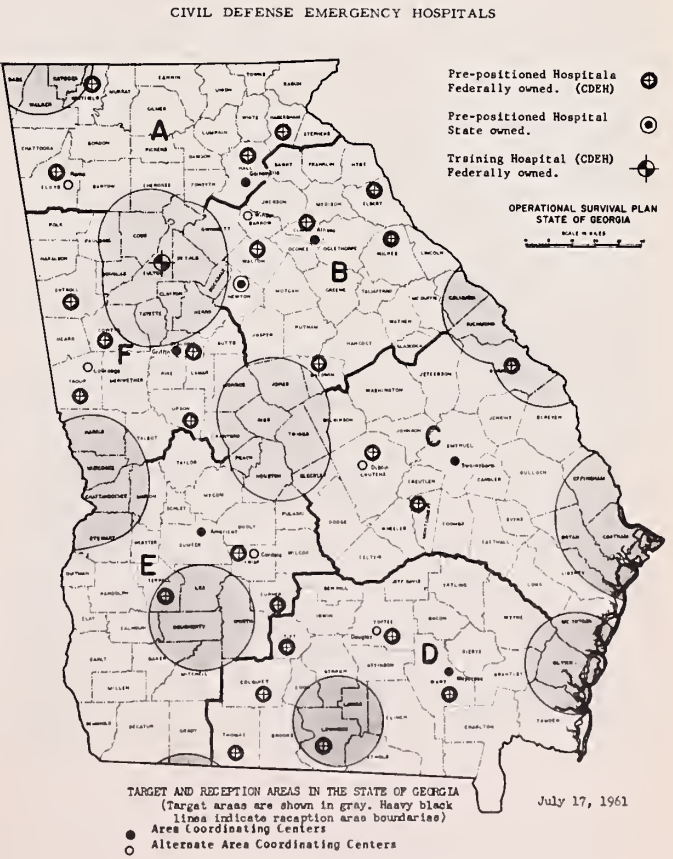
Some of Georgia's counties and all major cities already have such plans. Copies of a sample health services plan are available for study upon request. Recent disasters in some of our largest cities that had such plans, however, emphasized the fact that frequent practice runs are necessary to make these plans workable. Existing local plans are now being revised. Many other political subdivisions are preparing plans. The summary of these should be published in the local newspapers so that the population at large would know what to do in an emergency.

The Federal Government has, during the past several years, prepositioned 26 packaged 200-bed Civil Defense Emergency Hospitals throughout Georgia. With few exceptions, each one of these is under the supervision of a local hospital, which has assumed the responsibility for rotating expendable drugs and other supplies and thus have them ready for immediate use at all times. The state has asked for more of these hospitals. If and when these are made available, full particulars will be given to the medical profession.

Local communities can request permission from State Civil Defense Headquarters to use one or more of these prepositioned packaged hospitals only in case of major disasters where existing hospital facilities are not adequate to take care of the disaster. They would need to assure Civil Defense Headquarters that they have trained personnel to operate the valuable equipment, an adequate building in which to set it up and adequate truck transportation to bring in the equipment. The staff for each of these hospitals is ideally composed of 300 persons, including 18 physicians, three hospital administrators, 33 nurses, five anesthetists, two pharmacists, 118 trained aids, plus other needed skills.

Dentists and veterinarians may be used extensively since there could be a shortage of physicians. Personnel can set up the equipment with 120 man hours of labor in a floor area of 15,000 sq. ft. Remember also that in case of atomic disaster, it is estimated that 80 per cent of the 1,500,000 hospital beds available in the United States today would be destroyed or unusable as a result of a mass attack. This emphasizes the importance of these prepositioned packaged civil defense emergency hospitals. Two or more nearby communities may have to combine to staff one civil defense emergency hospital where there is shortage of critical skills.

It is advisable that we plan now to train additional personnel to operate these hospitals. Familiarity with the contents of the 200-bed emergency hospital is essential to this planning by the medical profession. Efforts are presently being made to obtain a central location for Georgia's Training Hospital and it is hoped that when this center is established every physician in Georgia will visit it and thoroughly study it.



MONILIAL GRANULOMA

Treatment With Amphotericin B and Dermabrasion

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- *This paper reports the 19th case of monilial granuloma having the unique features of hypergammaglobulinemia and a M. audouini infection.*

THRUSH, INTERTRIGO and vaginitis are among the common diseases caused by *Candida albicans*. This organism has also been responsible for many bizarre infections,¹⁻⁶ one of which is monilial granuloma, an often fatal form of candidiasis.

Hauser and Rothman⁷ in 1950 reviewed the world's literature and added an additional case of this rare disease. Since that time four more cases have been reported.

Case Report

A 12 year old colored female presented with an eruption of the face, scalp, fingernails, mouth and arms of about eight years duration. Her appearance was very similar to the previously described cases.



Figure 1. Appearance before treatment.

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(Figure 1) Besides the oral mucous membrane involvement her teeth were all rotted, the gums were tender and bled at the slightest touch.

The finger tips were club shaped and the nails were thickened, grey and deformed with exception of the fifth finger on one hand. (Figure 2)



Figure 2. Involvement of finger nails before therapy.

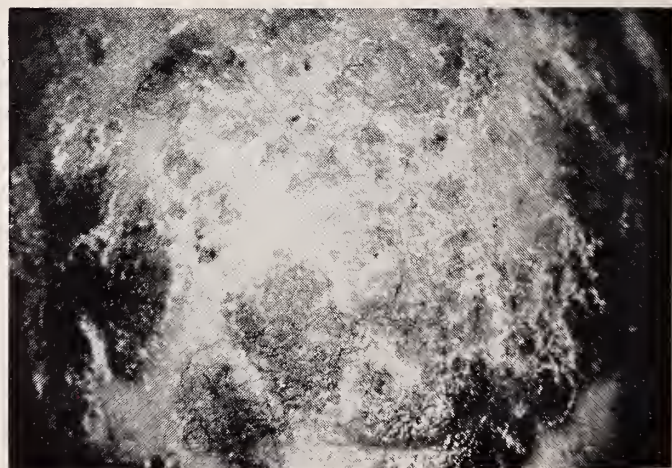


Figure 3. Top of head before therapy. Note almost complete absence of hair.

The scalp showed numerous reddish-brown hyperkeratotic, verrucous growths on a soft, highly vascular base through which protruded a few fragmented hairs which fluoresced brilliantly under Wood's light. (Figure 3) The only normal hair growth was in a fringe around the scalp. On the forehead, nose and chin were growths similar to those on the scalp. Below the left eye, on the left arm, and above the upper lid were firm, dark brown hyperkeratotic circinate lesions. (Figure 4)



Figure 4. Note circinate lesions due to *M. audouini* below eye extending across bridge of nose.

Cultures of the fluorescent hairs and from the lesions of the cheek, arm and scalp were positive for *M. audouini*. Cultures from the deeper portions taken from punch biopsies of the facial granulomas from the buccal mucosa and from the nails grew *C. albicans*.

Pathology report of the biopsies is as follows: "The sections show hyperplasia of the epidermis with hyperkeratosis. There is papillary elongation. There is a very intense infiltration of plasma cells and lymphocytes. In the keratin poorly staining mycelia-like objects are seen which do not follow the general layering of the keratin. PAS stain shows the presence of mycelia in the keratin layer and also in the former location. The predominant distribution of the fungi is in the follicles."

The girl was started on griseofulvin, one gram daily, and contrary to reports of griseofulvin causing a flareup of yeast infections the monilial lesion subsided somewhat. The lesions, due to *M. audouini* cleared completely but after the initial slight response the monilial lesions remained status quo. When cultures became negative for *M. audouini* the patient was admitted to the Glynn-Brunswick Memorial Hospital for Amphotericin B therapy.

Other than the previously described lesions no abnormalities were found on physical examination.

Laboratory examination included a normal hemogram, urinalysis and chest X-ray. The total protein was 9.3 mgm per cent and the serum electrophoresis

revealed a hypoalbuminemia and hypergammaglobulinemia. The gamma globulin resembled the high sharp peak as seen in multiple myeloma. (Figure 5)

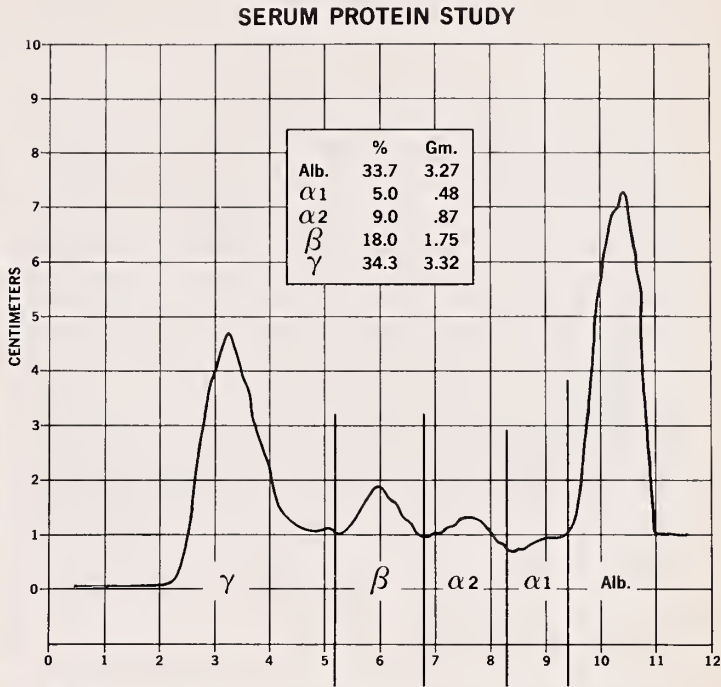


Figure 5. Note high gamma globulin with myeloma type peak.

Daily intravenous administration of 10 mg. of Amphotericin B over a six hour period was begun. The first and second day of therapy was accompanied by fever, nausea and mild arthralgia which was controlled by aspirin. There was a gradual increase in general malaise with the development of anorexia.



Figure 6. Surface of scalp one month after cessation of intravenous Amphotericin B.

On the 11th day of therapy the BUN rose to 36.1 mgm per cent and therapy was discontinued with little change in the appearance of the lesions. The patient was discharged and followed as an out-patient. The BUN dropped about 20 per cent each ten day period. Three weeks after cessation of therapy it was noted that the lesions of the scalp were thinning out. The surfaces had more the appearance of crusts with the edges retracting from

pink, uninvolved skin. The lesions of the face had also "dried out" to some extent but there was marked bleeding with any attempt to remove the crusts. (Figure 6 and 7) Three weeks later the scalp



Figure 7. Appearance of lesions above the brow after I.V. Amphotericin and after dermabrasion of one lesion above left brow.

was almost clear but there was no further change in the face lesions. Under Xylocaine plus epinephrine anesthesia the lesion above the left brow was removed by dermabrasion. Frigiderm was completely ineffective in freezing the highly vascular, hyperkeratotic lesion. Amphotericin B, 100 mgm/30 gm Aquaphor was applied BID after removal of the crust on the sixth day. The immediate results were excellent. Two weeks later the remaining facial lesions were removed by dermabrasion and the use of topical Amphotericin B was instituted. It has now been one year since the last procedure. All monilial lesions are clear and hair is growing on the scalp. (Figures 8, 9, 10, 10A)

Comment

Blank, Roth, et al.^{8,9} found an antimonal, antifungal factor in normal serum. Our patient's abnormal serum protein pattern and the report by Papazian and Koch¹⁰ of an elevation of the gamma globulin to 32 per cent of the total protein in their patient with monilial granuloma points to a defect

in the immune mechanism of these people as a pathogenetic factor rather than strain difference of the organism. In the light of these findings it can be postulated that the normal antimonal factor lies in the gamma globulin and that these patients produce an ineffective or "incomplete" antibody.

It is noteworthy that the *M. audouini* lesions were cleared by culture after one month on Griseofulvin. Seven months later the audouini infection appeared again in the identical areas where it was originally seen. Griseofulvin was again instituted with the lesion of the arm gradually clearing. The ear worsened and after five months of treatment the dose has been increased to two grams a day.

Amphotericin B has been found to be extremely useful in the treatment of a number of systemic mycoses including candidiasis. It has been administered in several forms and by many routes. A solution has been used in local infiltration, intrathecally and intra-articularly, instilled into an empyema cavity and into the urinary bladder and even injected into the cornea. It has been passed through a jejunostomy tube and has been used as an ointment and in tablet form.

All reported side effects have been reversible with discontinuance of the drug. These side effects have varied in severity from mild temperature elevations and gastrointestinal upset to grand mal seizures and renal damage.

The case presented here is the first known report of monilial granuloma treated with topical Amphotericin B following dermabrasion. Continued use of the Amphotericin ointment over a two month period caused no elevation of the BUN with this patient, who had evidenced a rapid rise of the BUN with intravenous therapy. It is therefore surmised that topical Amphotericin will be a safe, effective antimonal drug.

Summary

This paper presents a case of monilial granuloma associated with an *M. audouini* infection treated successfully with griseofulvin. Amphotericin B and dermabrasion.

Alterations in the serum proteins supports the hypothesis that this reaction to *Candida* is due to

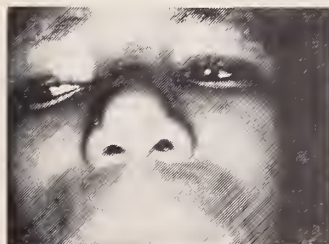


Figure 8. After dermabrasion plus topical Amphotericin. Compare with Figure 4.

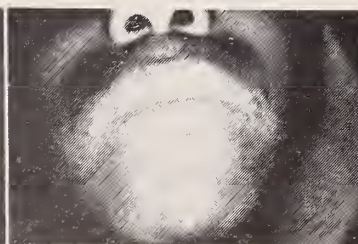


Figure 9. After dermabrasion plus topical Amphotericin. Compare with Figure 1.

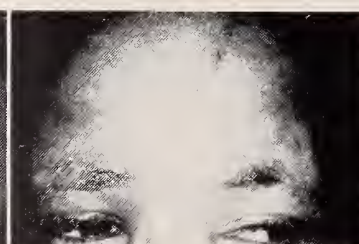


Figure 10. After dermabrasion plus topical Amphotericin B. Compare with Figure 10a.



Figure 10a. Closeup of lesions of forehead before any therapy. Compare with Figures 7 and 10.

an immunologic defect rather than a reaction to a particular strain of yeast.

This patient has a filamentous fungus evidently resistant to griseofulvin. Studies are now being carried out to determine if this is so.

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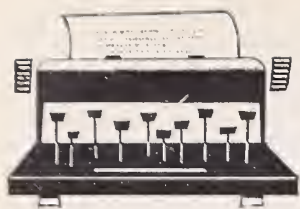
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An Invitation to Savannah

HEREWITH GREETINGS to all members of the Medical Association of Georgia and a most cordial invitation to attend the 108th annual session of that body when it convenes in Savannah, Georgia's First City, on May 6, 7, 8, and 9. Just as that famous Indian Chief, Tomochichi, welcomed General James Oglethorpe to the shores of the Savannah River in 1733, so the Georgia Medical Society welcomes you in 1962. While you are here in Savannah and Chatham County, every effort will be made to make your stay a pleasant, profitable, and enjoyable one.

Our hotels and motels, restaurants and stores are at your disposal and will take care of your bodily needs and creature comforts.

A fine scientific program with 18 out-of-state speakers as well as fine presentations by members of the Association has been arranged. In addition, the 17 specialty societies have scientific programs arranged according to their special interests. You will learn what progress your Association has made during the past years and what it foresees in the future. And by using your vote, you will be able to have your say about its future.

For entertainment and recreation, our beaches, our historical sights, our golf courses, our water-

ways and numerous other facilities are available. Our natural beauties, our trees, parks and gardens, should be at their best at that time. Each specialty group has arranged luncheon or dinner get-togethers for their individual members, and at these and at the alumni banquets, hands can be shaken and old friendships renewed and toasted. The Georgia Medical Society takes pleasure in extending to all an invitation to be its guest on Tuesday, May 8th at a reception preceding the annual President's Dinner, for which special entertainment has been arranged.

For the ladies, Lord bless 'em, special efforts are being made with an unusually active and energetic group of the local ladies in charge of arrangements and they are only too eager to show off their hospitality and home town to their cohorts from around the state.

So, on behalf of the Georgia Medical Society, the people of Savannah and Chatham County, I urge you to be in Savannah in May to enjoy your convention and our hospitality.

*John Kirk Train, M.D.
President, Georgia Medical Society*

Anticoagulant Therapy in Cerebral Atherosclerosis

SIGNIFICANT ADVANCES have been made in the management of the sequellae of the accomplished cerebral infarction, but the prevention of the infarct remains one of the most pressing problems confronting the clinician and investigator. Anticoagulants have seemed effective in the treatment of coronary and peripheral atherosclerosis therefore it seemed logical that this form of therapy be tried in cerebral atherosclerosis. Early reports were favorable but these studies were difficult to evaluate and the results inconclusive. In an effort to provide a clearer answer to the problem a nationwide cooperative

study was formed, sponsored by the National Institute of Neurological Diseases and Blindness. All the members of the group used the same protocol which included a non-biased randomized method of assigning patients to the treatment and control groups. The patients were divided into three categories, those with accomplished cerebral infarctions, those with progressive strokes, and those with transient ischemic attacks.

Interim reports of the results of these studies have been published^{1,2} and a final report is to appear in Vol. 41 of the *Proceedings of the Association for*

Research in Nervous and Mental Diseases. The results of this study can be summarized as follows: 1) the use of anticoagulants had no favorable effect on the natural history of the accomplished cerebral infarction. Indeed, there were more fatalities in the group receiving anticoagulants. This was predominantly due to fatal hemorrhagic accidents related to anticoagulant therapy. 2) In the progressive stroke there was some evidence that the incidence of worsening of neurologic deficit was less in the anticoagulated group. There is some question, however, as to whether the dangers of this form of therapy outweigh its potential benefits. 3) In patients with transient ischemic attacks there was a reduction in the total number of attacks in the treatment group. It is noteworthy that the highest incidence of recurrent transient ischemic attacks occurred in the first two months after the patient was admitted to the study. There was no significant difference between the treatment and control group in the incidence of development of a persistent neurologic deficit, three of 20 patients in the control group having a moderate and one a mild progression of infarctions as opposed to one of 24 patients in the treatment group having a severe progression. Based on this study it would also appear that the danger of imminent infarction in patients with transient

ischemic attacks is less than had been previously supposed.

Similar results have been published by the Neurology Section of the Veterans Administration Co-operative Study of Atherosclerosis. Reports from the Neurology Section at the Mayo Clinic covering a longer period of observation in a non-controlled study suggest that anticoagulants are more effective than the other studies would indicate.

Is the problem for the practitioner any less difficult as a result of these studies? If he is looking for a definitive answer regarding the use of anticoagulants in cerebral thrombosis the studies will be disappointing. If he is looking for guide lines to help him arrive at his own conclusions then the studies will be of help. In the final analysis the decision as to the use of anticoagulants is an individual one, based on the patient's disease, the logistics of the use and control of anticoagulant therapy, and the relative availability of other forms of treatment.

Herbert R. Karp, M.D.

Department of Neurology, Emory University.

References

1. Transactions of the Third Princeton Conference of Cerebrovascular Disease, Siekert, Robert G. and Whisnant, J. P., Eds. Grune and Stratton, New York, 1961.
2. International Conference on Vascular Disease of the Brain, Neurology 11:; No. 4, Part 2, April 1961.

Local Anesthetic Drugs

LOCAL ANESTHESIA derives its name from the assumption that the anesthetic drug exerts its effect primarily at the site of injection. This is true, when one considers only the anesthetic properties that the drug invokes. These drugs eventually enter the general circulation and are transmitted thereby to the organs which metabolize and excrete them. In this passage, they of necessity come in contact with the central nervous system and the myocardium, as well as the peripheral vascular beds. So-called reactions to the local anesthetic drugs are the result of this systemic transmission. The toxicity of these agents, therefore, depends on the concentration attained in the organs involved in this eventual perfusion. For a given concentration, reactions will obviously be of a different intensity, depending on the condition of the patient at the time. Thus, the older and debilitated individual may not tolerate the same circulating level as would the healthy, young patient.

Since the symptomatology of such responses is somewhat variable, it is wise to always view with suspicion the patient who becomes apprehensive or

jittery during the course of surgery under local techniques. Although the symptoms of central nervous system stimulation may be missed in the rapidly occurring (seemingly anaphylactic) reactions occasionally seen with local anesthetic drugs, it is more common that the signs of central nervous system stimulation are readily apparent before cardiovascular collapse occurs. Prevention of such reactions is not accomplished by a barbiturate, except in doses far greater than that routinely given before the administration of local or regional anesthesia. In some instances, the prior administration of barbiturate may camouflage a mild central nervous system reaction, but this is not a demonstration of the prevention of such a reaction.

The accompanying article on "The Toxicity of Local Anesthetic Drugs" by Dr. Charles R. Allen, from the University of Texas, is interesting from a standpoint of the probable development of a mechanism whereby new and existing local anesthetic drugs can be tested in order that their production of untoward reactions in the human can be anticipated

with a higher degree of accuracy. It is interesting that of the six drugs utilized in this study, three are in common clinical use today, whereas the other three have somewhat fallen by the wayside for use in other than subarachnoid anesthesia. Procaine (Novocain®), Chloroprocaine (Nesacaine®), and Lidocaine (Xylocaine®) are probably the three most common drugs utilized for simple infiltration and regional nerve blocking procedures. Cocaine, Tetracaine (Pontocaine®), and Dibucaine (Nupercaine®) have become somewhat limited in their applications,

being primarily now reserved for usage as topical agents. Pontocaine and Nupercaine are still utilized for spinal anesthesia, and the absence of toxic reactions from this source is probably explained by the relatively slow rate of absorption from subarachnoid space. In previous years clinical experience has been responsible for the deletion of these latter three drugs from other usages, and further clinical experience seems to indicate that their use as topical anesthetics may be increasingly lessened. In any event, the method of utilizing live tissue cultures in the evaluation of new local anesthetic agents (so-called) which will undoubtedly appear in the future.

AMA LEGISLATIVE CONFERENCE HELD IN CHICAGO

During the last week in January of this year more than 400 physicians and lay staff personnel from medical societies, state and local, assembled in Chicago for a Medical Legislative Conference sponsored by the American Medical Association.

The principal topic of discussion was, of course, the King-Anderson Bills, or more precisely, how to fight and defeat them.

The mood of the meeting was set by Dr. Leonard Larson, AMA President with his opening address entitled "You Can Tell Your Children." Dr. Larson struck a responsive cord with the group when he said that medicine's fight to preserve its right to be free is really a fight to pass on to our children the same heritage we were given by our fathers.

The group was given a frank appraisal of the status of Social Security health care legislation by Dr. Ernest B. Howard, Assistant Executive Vice President of the AMA. Dr. Howard advised the meeting of a proposed strategy change by the Senate Leadership to bypass both the House Ways and Means Committee and the Senate Finance Committee. Such strategy would involve amending a bill already approved by the House by inclusion of the language of the Anderson Bill which is identical to the King Bill now pending in the House Ways and Means Committee. Should such a bill be approved by the Senate it would then go to a Conference Committee composed of members from both Houses of Congress but would not be referred to or ever considered by either Ways and Means or Senate Finance.

One of the highlights of the two day meeting was an address by the Honorable Bruce Alger, Member of Congress from Dallas, Texas. Mr. Alger, a member of the powerful Ways and Means Committee of the House of Representatives stressed the necessity for doctors of medicine to join in the great struggle being waged between socialism and representative government in this country. He stated that "if we don't get a conservative

Congress in the next election, all of us will be socialized." He added that if the AMA (meaning the individual member of the AMA) would follow through with its legislative blueprint, it could defeat H.R. 4222 (King Bill) in this current session of Congress.

The underlying thought or connecting thread running through the Congressman's talk was the need for the medical profession to exert itself in behalf of those issues, medical and non-medical, which will restore economic, political and social sanity to the Federal Government.

Congressman Alger pounded home the idea that informed, educated and enlightened people must take it upon themselves to educate the electorate, lobby intelligently for the good of the country and above all, elect responsible officials to public office.

The afternoon session of the first day of the meeting featured Regional Workshop Sessions. States in groups of four, six and eight gathered together to discuss and outline for the mutual benefit of each, specific ideas, techniques and projects for effective legislative action.

Durwood Hall, doctor of medicine turned Congressman from Missouri, delivered the principal speech on the closing day of the meeting. Congressman Hall's talk entitled "Uncle Sam Needs You" was what would be called in theatrical circles a "show stopper." He emphasized and re-emphasized the crying need for the American people to communicate with their Congressional representatives in Washington. He placed particular stress on the members of the House Ways and Means Committee and advised the medical profession to continue to communicate with these men as well as with the remaining 412 members of the House.

The Conference served as a real stimulus to the 400 plus who attended. To quote Congressman Alger, if we will but follow through on the Legislative Blueprint set by AMA, we will defeat the King Bill during this session of Congress.

Mark These Dates on Your Calendar

MAY 6-9, 1962

These are the dates for the

ANNUAL SESSION
of the
**MEDICAL ASSOCIATION
OF GEORGIA**



to be held in

SAVANNAH, GEORGIA

at the

DeSoto Hotel

Annual Session Time Is Almost Here . . .

APPLICATION FOR HOTEL AND MOTEL ACCOMMODATIONS

Medical Association of Georgia 1962 Annual Session

May 6, 7, 8, and 9, 1962, Savannah

A Housing Bureau has been established for your convenience in making your hotel reservations in Savannah for the 1962 ANNUAL SESSION of the Medical Association of Georgia. Comparable room rates are listed. Use the Reservation Blank below. Please specify your first, second, and third choice hotel or motel. All requests for reservations should give: (1) anticipated date and hour of arrival; (2) date and approximate hour of departure, and (3) names and addresses of all persons who will occupy the accommodations. ALL RESERVATIONS MUST BE CLEARED THROUGH THE HOUSING BUREAU. Since all requests for rooms will be handled in chronological order, you should mail your application as early as possible. All reservations will be confirmed.

Hotels	Single	Double	Twin
DeSoto Hotel (Headquarters Hotel)	\$ 8.00-\$12.00	\$10.00-\$14.00	\$11.00-\$14.00
Manger Hotel	\$ 8.50	\$10.00	\$11.00
Gen. Oglethorpe Hotel (Villa Rooms)	\$10.00-\$12.00	\$16.00-\$18.00	\$16.00-\$18.00
Whitney Hotel	\$ 6.00		\$ 9.00

Motels	
Town and Country Motel	2 to a room - \$10.00 3 to a room - \$11.00 4 to a room - \$12.00 No singles — all rooms have 2 double beds
Howard Johnson's Motor Lodge	\$ 8.00 \$ 9.00 \$11.00
Alamo Plaza	\$ 7.00 \$ 8.00 \$ 9.00
Motel Stanley	\$ 7.50 \$1.50 per person over 2 people \$ 8.50 - 2 to a room \$10.00 - 3 to a room \$11.50 - 4 to a room

All rates plus 3% sales tax. All hotel reservations held until 6 p.m. without deposit. If arrival after 6 p.m., first night's rental required to guarantee. Deposit required on all motel rooms.

Tear off and send to:

Please Type or Print

HOUSING BUREAU
MEDICAL ASSOCIATION OF GEORGIA
Attn: Mrs. Standard
DeSoto Hotel, Savannah, Georgia

Please reserve the following accommodations for me for the 1962 Annual Session of the Medical Association of Georgia:

Hotel or Motel Preference	Kind or Accommodations Desired
1st Choice _____	<input type="checkbox"/> Single Room at \$ _____ to \$ _____
2nd Choice _____	<input type="checkbox"/> Double Room at \$ _____ to \$ _____
3rd Choice _____	<input type="checkbox"/> Twin Bedroom at \$ _____ to \$ _____
	<input type="checkbox"/> Other Type _____
Arrival Date _____	Hour _____ A.M. _____ P.M.
Departure Date _____	Hour _____ A.M. _____ P.M.

THE NAME OF EACH HOTEL GUEST MUST BE LISTED. Include the names of all persons for whom you are requesting reservations and who will occupy the room(s):

Name of Occupant(s)	Address
_____	_____
_____	_____
_____	_____

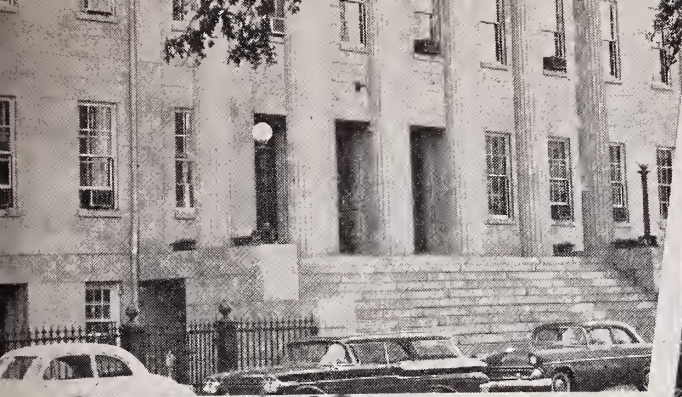
Individual Requesting Reservations

Name _____

Address _____

City _____ Zone _____ State _____

If the hotels or motels of your choice are unable to accept your reservation, the Housing Bureau will make reservations to fit your specifications elsewhere.



CUSTOM HOUSE



PIRATES HOUSE



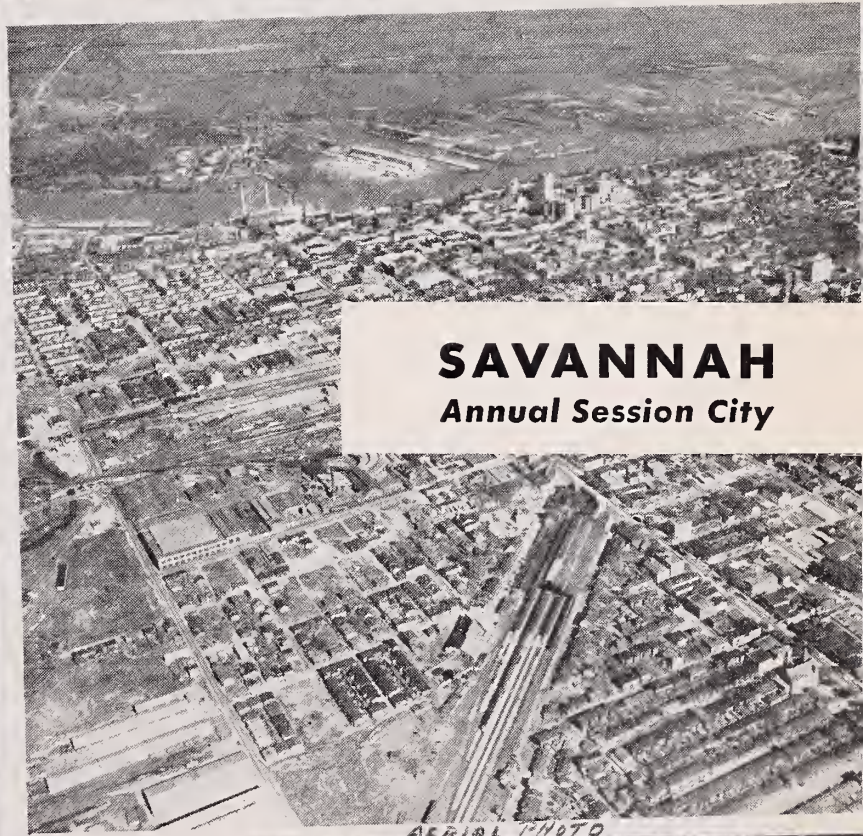
SKYLINE



FORT
PULASKI



ART ACADEMY



SAVANNAH

Annual Session City

AERIAL PHOTO

Juliette Low's
BIRTHPLACE

OLD
HARBOR
LIGHT

108th Annual Session Official Call

Extended to All Officers and Members of the Medical Association of Georgia

THE 108TH ANNUAL SESSION of the Medical Association of Georgia will be convened at the DeSoto Hotel, Savannah, Georgia on May 6, 7, 8, and 9, 1962.

The MAG Official Registration Desk will be located at the hotel Rotunda Room adjacent to the Scientific Exhibits, Commercial Exhibits, and the entrance to the two main Meeting Halls. Registration for Association members and guests will be conducted Sunday, May 6 from 1:00 P.M. to 6:00 P.M.; Monday, May 7 from 8:00 A.M. to 5:00 P.M.; and Tuesday, May 8 from 8:00 A.M. to 5:00 P.M.

MAG General Business Sessions

The Association will convene the First General Business Session Sunday, May 6 at 2:00 P.M. in the DeSoto Ballroom for the purpose of nominations to MAG Offices and Awards. The Second General Business Session will be held Monday, May 7 at 12:00 noon in the DeSoto Ballroom, at which time the outgoing MAG President will make his report to the membership and the MAG President-Elect will outline his program for the coming year over which he will preside as MAG President. The Third General Business Session is set for Wednesday, May 9 at 11:00 A.M. in the DeSoto Ballroom. At this meeting, MAG Awards are presented, new MAG Officers are installed, and the entire Annual Session is adjourned.

MAG House of Delegates

The First Session of the Association House of Delegates will be convened Sunday, May 6 at 5:00 P.M. in the DeSoto Ballroom, at which time reports and resolutions will be introduced to the House for referral to House Reference Committees. Also scheduled for the Delegates at this session is an address entitled "The Triangle of Medicine — Re-

search, Education and Patient Care" by Hugh H. Hussey of Washington, D.C. Dr. Hussey is Chairman of the AMA Board of Trustees and Dean of the Georgetown University School of Medicine. Immediately following this First Session of the House, all delegates are cordially invited to attend the traditional MAG Delegates and Exhibitors Social Hour scheduled for 6:30 P.M. in the Gold Room.

House Reference Committees will convene Monday Morning and Monday Afternoon, May 7 to make recommendations to the House on all reports and resolutions. Reference Committee meeting time and meeting rooms will be published in the Program and in the House of Delegates Handbook.

The Second and Final Session of the House of Delegates will be held Wednesday, May 9 at 9:00 A.M. in the DeSoto Ballroom. Reference Committees will present their recommendations on all reports and resolutions before the House and final action on this business will be voted by the members of the House.

All MAG Members, Auxiliary Members and their guests are welcome to attend sessions of the House of Delegates.

Scientific Meetings

MAG Scientific Section and Joint Section Meetings are scheduled for Sunday Afternoon, May 6 from 2:30 P.M. to 5:00 P.M.; Monday Morning, May 7 from 9:00 A.M. to 12:00 noon; Tuesday Morning, May 8 from 9:00 A.M. to 12:00 noon and again Tuesday Afternoon, May 8 from 2:30 P.M. to 5:00 P.M. There will be no Official MAG Section or Joint Section Meetings scheduled for Monday Afternoon, May 7. Meeting Rooms for each MAG Section or Joint Section Meetings are noted below in the MAG Program Brief and in the complete program on the following pages.

MAG PROGRAM BRIEF

Sunday, May 6

- 2:00 p.m. MAG General Business Session, *DeSoto Ballroom*
- 2:30 p.m. Pediatrics and Surgery Joint Section Meeting, *DeSoto Ballroom*
- 2:30 p.m. Anesthesiology Section Meeting, *Cotillion Room*

- 2:30 p.m. Dermatology and E.E.N.T. Joint Section Meeting, *Georgian Room*
- 2:30 p.m. Orthopedics Section Meeting, *Habersham Room*
- 2:30 p.m. Radiology Section Meeting, *Camellia Room, Manger Hotel*

- 5:00 p.m. MAG First Session House of Delegates, *DeSoto Ballroom*
 6:30 p.m. MAG Delegates and Exhibitors Social Hour, *Gold Room*

Monday, May 7

- 8:00 a.m. MAG House of Delegates Reference Committee #1, *Room 400*; Reference Committee #2, *Room 450*; and Reference Committee #3, *Red Surrey Lounge*
 9:00 a.m. Chest, Diabetes, Medicine and Psychiatry Joint Section Meeting, *DeSoto Ballroom*
 9:00 a.m. Obstetrics, Urology, Pediatrics and Surgery Joint Section Meeting, *Cotillion Room*
 9:00 a.m. Radiology, Orthopedics and Pathology Joint Section Meeting, *Georgian Room*
 12:00 noon MAG General Business Session, *DeSoto Ballroom*

- 2:30 p.m. MAG House of Delegates Reference Committee #4, *Room 400*; and Reference Committee #5, *Room 450*

Tuesday, May 8

- 9:00 a.m. MAG General Scientific Session (G.P. Day), *DeSoto Ballroom*
 2:30 p.m. General Practice and Psychiatry Joint Section Meeting, *DeSoto Ballroom*
 2:30 p.m. Medicine, Chest and Diabetes Joint Section Meeting, *Cotillion Room*
 2:30 p.m. Obstetric Section Meeting, *Georgian Room*

Wednesday, May 9

- 8:30 a.m. Medical-Legal Workshop, *Cotillion Room*
 9:00 a.m. MAG Second Session House of Delegates, *DeSoto Ballroom*
 11:00 a.m. MAG Final General Business Session, *DeSoto Ballroom*

Specific Information

Registration

The Medical Association of Georgia Official Registration Desk will be located near the Rotunda Room in the DeSoto Hotel. The desk will be adjacent to the entrance and exit for scientific exhibits, commercial exhibits and the two main Meeting Halls. The desk will be open for the registration of MAG members and guests on Sunday, May 6 from 1:00 P.M. to 6:00 P.M.; Monday, May 7 from 8:00 A.M. to 5:00 P.M. and Tuesday, May 8 from 8:00 A.M. to 5:00 P.M.

MAG members and guests are requested to register at the MAG Registration Desk *immediately on arrival* at the DeSoto Hotel (Headquarters Hotel) to obtain badges and programs. *No one will be admitted* to the Exhibit Halls and Meeting Rooms without official registration badges.

Message Center

A Message Center will be maintained at the MAG Official Registration Desk for the convenience of the membership. Pages from the Woman's Auxiliary to MAG will staff this center during the entire session. All notices of an official nature will be posted on the Official Bulletin Board at this Message Center adjacent to the MAG Registration Desk.

MAG Headquarters Office and Press Room

The MAG Headquarters Office Staff will maintain a Headquarters Office Room at the DeSoto Hotel for the purpose of secretarial staff activity in conjunction with the conduct of Association business during the meeting.

A MAG Press Room will also be available for use by newspaper, radio and television media personnel during the entire Annual Session.

MAG House of Delegates

The MAG House of Delegates will convene Sunday, May 6 at 5:00 P.M. in the DeSoto Ballroom. MAG Delegates will reconvene for the Second Session of the House of Delegates on Wednesday, May 9 at 9:00 A.M. in the DeSoto Ballroom.

All MAG Delegates are requested to attend both of these sessions of the House *at least 15 minutes prior to the time they convene* so that delegates may be registered without delay of the meetings. Special Delegates Registration, for both Sessions of the House, will be conducted just outside the entrance to the DeSoto Ballroom where the delegates are scheduled to meet. During this registration, delegates credentials are checked and delegates are given special registration badges which certify the delegates right of vote during sessions of the House.

MAG Memorial Service

The Medical Association of Georgia will hold its annual Memorial Service at the First Session of the House of Delegates on Sunday, May 6 at 5:00 P.M. in the DeSoto Ballroom. All members and guests are cordially invited to attend this service which is held in memory of the members who have died during the past year. The event will honor the service and contributions of the following medical practitioners:

Specific Information

Social Events

Information about social events planned in conjunction with the MAG Annual Session and the necessary admission tickets will be available at the MAG Official Registration Desk. As accommodations for such social events are limited, your cooperation in purchasing tickets at the time you register is requested. The traditional Alumni banquets and invitations to the President's Banquet will be arranged at the Registration Desk.

Scientific Exhibits

Scientific Exhibits will be displayed adjacent to the Commercial Exhibits at the entrance to the two main meeting halls. The Scientific Exhibits are prepared by physicians who will be at their exhibit to discuss their presentation with the membership. All physicians are urged to visit each Scientific Exhibit in the interests of professional education. Awards for outstanding Scientific Exhibits will be presented at the MAG Final General Business Session on Wednesday, May 9 at 11:00 A.M. in the DeSoto Ballroom.

Commercial Exhibits

Approximately 45 Commercial Exhibits will be displayed in exhibit booths in the corridor entrance to the two main Meeting Halls just adjacent to the MAG Registration Desk. These exhibits will provide technical information of importance on the latest products and services available to the medical profession.

It is *extremely* important that every member visit each of these exhibits and register with the exhibitor. Your cooperation is *requested* since these displays are designed and shown specifically to benefit the profession.

The Commercial Exhibitor plays an extremely important role in making the MAG Annual Session possible and the Association Commercial Exhibits Committee strongly urges your participation in this area of MAG activity. *Please be sure to visit each and every Commercial Exhibit booth.* A list of those Commercial Exhibitors already participating in the MAG Session is as follows:

Booth Number	Name of Company
1	Schering Corporation, Bloomfield, New Jersey
2	Parke, Davis & Company, Detroit, Michigan
3	Roche Laboratories, Nutley, New Jersey
4	Wachtel's Physician Supply Co., Savannah, Georgia

M. P. Agee, Augusta, May 26, 1961
C. Raymond Arp, Atlanta, October 5, 1961
E. A. Barger, Waynesboro, August 27, 1961
Charles H. Bloodworth, Atlanta, June 21, 1961
F. S. Belcher, Monticello, July 27, 1961
T. L. Byrd, Atlanta, December 19, 1961
Enoch Callaway, LaGrange, September 26, 1961
Ralph H. Chaney, Augusta, May 3, 1961
Frederick W. Cooper, Jr., Atlanta, August 1, 1961
Forrest L. Cosby, Columbus, August 26, 1961
John B. Cross, Atlanta, July 23, 1961
Robert W. Eilers, Smyrna, May 4, 1961
Charles S. Floyd, Loganville, January 1, 1962
Elmer L. Fry, Atlanta, October 23, 1961
M. G. Hendrix, Ball Ground, September 26, 1961
Pierre C. Herault, Jr., LaGrange, June 14, 1961
S. A. Koff, Atlanta, December 18, 1961
E. M. McDonald, Winder, March 25, 1961
G. W. Mountain, Augusta, September 18, 1961
J. H. Nicholson, Madison, November 12, 1961
Harry B. Nunnally, Monroe, November 16, 1961
Leon D. Porch, Macon, May 25, 1961
B. C. Powell, Villa Rica, July 25, 1961
Eustace H. Prescott, LaGrange, September 8, 1961
M. H. Roberts, Atlanta, July 29, 1961
L. C. Roughlin, Atlanta, September 9, 1961
E. O. Scharnitzky, Augusta, December 22, 1961
Alvin E. Siegel, Macon, December 10, 1961
Marshall R. Sims, Atlanta, October 9, 1961
S. J. Sinkoe, Atlanta, September 14, 1961
G. B. Smith, Rome, August 7, 1961
H. A. Smith, Americus, November 7, 1961
W. P. Smith, Bowdon, October 27, 1961
William Charles Wansker, Atlanta, January 6, 1962
Howell A. Wasden, Jr., Pavo, October 16, 1961
J. H. Whiteside, Statesboro, April 19, 1961

Specialty Society Meetings, Luncheons and Dinners

Specialty Societies have planned meetings, luncheons and dinners for the membership of their organizations to be held in conjunction with the MAG Annual Session. These events are listed in the Official MAG Program in the order of the date and time the event is scheduled — under Social Events. As these sessions are limited to the membership of the specialty society sponsoring the affair, they are not considered a part of the Official MAG Program.

Woman's Auxiliary to MAG

The Woman's Auxiliary to the Medical Association of Georgia will convene their 37th Annual Meeting in conjunction with the MAG Annual Session. The Auxiliary Registration Desk will be adjacent to the Gold Room in the DeSoto Hotel. The complete program giving times, dates and locations of Auxiliary meetings and functions will be found in this issue immediately following the program material of the MAG.

Specific Information

- 5 G. D. Searle & Co., Chicago, Illinois
- 6 Wachtel's Physician Supply Co., Savannah, Georgia
- 7 The Lanier Company, Atlanta, Georgia
- 8 Abbott Laboratories, North Chicago, Illinois
- 9 The Upjohn Company, Kalamazoo, Michigan
- 10 Mead Johnson Laboratories, Evansville, Indiana
- 11 Geigy Pharmaceuticals, Yonkers, New York
- 12 Ortho Pharmaceutical Corporation, Raritan, New Jersey
- 13 Wm. P. Polythress & Co., Richmond, Virginia
- 14 Charles C. Haskell & Company, Richmond, Virginia
- 15 Loma Linda Food Company, Arlington, California
- 16 Pfizer Laboratories, New York, New York
- 17 Vanpelt and Brown, Richmond, Virginia
- 18 The Dome Chemicals, Inc., New York, New York
- 19 The Warren-Teed Products Company, Columbus, Ohio
- 20 Smith Kline & French Laboratories, Philadelphia, Pennsylvania
- 21 Merck Sharp & Dohme, Jacksonville, Florida
- 22 J. B. Roerig & Company, New York, New York
- 23 Julius Schmid, Inc., New York, New York
- 25 Medco Products Co., Inc., Atlanta, Georgia
- 27 The Coca-Cola Company, Atlanta, Georgia
- 29 Ciba Pharmaceutical Products, Inc., Summit, New Jersey
- 30 Davies, Rose & Company, Limited, Boston, Massachusetts
- 31 Borden's Pharmaceutical Company, New York, New York
- 37 E. R. Squibb, New York, New York
- 38 Great Books With The Syntopicon, Towson, Maryland
- 39 The S. E. Massengill Company, Bristol, Tennessee
- 40 Physicians Products Co., Inc., Decatur, Georgia
- 41 Carnation Company, Los Angeles, California
- 42 U. S. Vitamin & Pharmaceutical Corp., New York, New York
- 43 Warner - Chilcott Laboratories, Morris Plains, New Jersey
- 44 Ross Laboratories, Columbus, Ohio

- 45 Sandoz Pharmaceuticals, Hanover, New Jersey
- 46 Eaton Laboratories, Norwich, New York
- 47 Reid Laboratories, Inc., Atlanta, Georgia

Eli Lilly and Company has designed a grant to help defray the expenses of MAG guest speakers attending the Association's 108th Annual Session as designated by the MAG Annual Session Committee, in lieu of an exhibit during this session.

Fifty-Year Members

Physicians who have practiced medicine for 50 years will be honored at the MAG Annual Session by the award of a 50-year pin and certificate. These awards will be presented at the MAG Final General Business Session on Wednesday, May 9 at 11:00 A.M. in the DeSoto Ballroom. The following list contains the names of all members of the Medical Association of Georgia who, as of the year 1962, have practiced medicine 50 years. It does not record the names of physicians who have already received gold membership cards. This is the class of 1912, as follows:

Homer Lumpkin Barker	Carrollton
James Gordon Brantley	Wrightsville
Ben Hill Clifton	Atlanta
Grover Cleveland Cole	Dallas
Albert Nathan Dykes	Columbus
Clifford Clay Elliott	Sargent (Deceased)
Bernard Lamar Helton	Sandersville
Henry Woodfine Minor	Atlanta
James L. Morris	Alpharetta
Francis C. Nesbit	Covington
Emory Robert Park	LaGrange
James Roscoe Sams	Covington
Egbert M. Townsend	Ringgold
Guy O. Wheelchel	Athens
James H. Whiteside	Statesboro (Deceased)

Golf

An open tournament has been arranged for MAG members at the Savannah Golf Club on the following dates: Sunday, May 6 — all day; Monday, May 7 — all day; and Tuesday, May 8 — morning only. Physicians wishing to participate should identify themselves as MAG members and *turn in their score card to the Club Pro marked MAG* so that the MAG Golf Committee may total scores for prize awards. Golf score prizes will be awarded at the President's Banquet, Tuesday evening, May 8.

Other golf courses available for non-tourney play include the Bacon Park Municipal Course, Mary Calder, Oglethorpe and Windsor Forest.

GUEST SPEAKERS



HUGH H. HUSSEY M.D.

Washington, D. C.

HUGH H. HUSSEY, M.D., is the Chairman of the Board of Trustees of the American Medical Association and is Dean of the Georgetown University School of Medicine.

He was graduated from Georgetown University and received his M.D. degree magna cum laude also from Georgetown. After one year of internship at Georgetown University Hospital and one year as a "fellow" in Medicine with Georgetown University he entered the private practice of medicine in the District of Columbia. At the same time, he acquired a strong teaching affiliation with Georgetown University School of Medicine, that has been uninterrupted to date.

In 1958 he was appointed Dean of the School of Medicine but retained his title of Professor of Medicine. At various times, he has held teaching, visiting, or consulting appointments at Georgetown University Hospital, the D.C. General Hospital, Mt. Alto Veterans Administration Hospital, Walter Reed Army Hospital, Glenn Dale Hospital and St. Mary's Hospital in Rochester, New York.

Dr. Hussey was elected to the Board of Trustees of the American Medical Association in 1956 and served as its Vice Chairman in 1960-61. During the period of 1940-56, he was Associate Editor of the *MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA*, and during the period 1951-59 was Medical Editor of the *GP*. He was certified by the American Board of Internal Medicine and is a member of the American Heart Association, the American College of Physicians, the Public Health Advisory of the District of Columbia, and the American Clinical and Climatological Association. In 1960 Dr. Hussey was appointed by the President of the United States as a member of the Board of Regents of the National Library of Medicine.

Dr. Hussey is the author of 56 scientific publications, many of them dealing with disorders of the peripheral vascular system or, more recently, with medical education.

He will speak at 5:45 P.M., Sunday, May 6, to the House of Delegates Meeting on "The Triangle of Medicine—Research, Education and Patient Care." A short synopsis of that presentation follows:

The three elements of the art and science of medicine traditionally are considered to be research, education and patient care. Although one or another of these elements can be viewed separately for purposes of analysis, such separation is artificial. The elements are truly inseparable—in that sense are a triangle.

It may seem natural or logical to represent the triangle in equilateral form, but historically, it has more often been distorted than not. Such distortion traditionally has provided a shape in which the longest side is patient care. Now there are evidences of a change from the traditional, and the question to remain intact. More specifically, is an enormous lengthening of the triangle's research limb economically, socially and scientifically acceptable?



COLEMAN MOPPER, M.D.

Detroit, Michigan

COLEMAN MOPPER, M.D. will present a paper, "Diagnostic Significance of the Eyelids" at 3:40 P.M., Sunday, May 6, to the Dermatology and EENT Joint Section Meeting. A short precis of that paper follows:

The eyelids are often involved and this type of dermatitis is seen frequently in a dermatologist's office. This dermatitis may be of external origin or may be associated with a systemic condition requiring considerable treatment. The eyelids will, at times, display diagnostic features which aid in establishing diagnosis of conditions which have a systemic nature. The author will attempt to limit the paper to the more important conditions as: Pyodermas, Contact Dermatitis, Neurodermatitis, Pediculosis, Atopic Eczema, Sarcoidosis, Tuberculosis, Herpes Simplex, Herpes Zoster, Xanthelasma, Pemphigus, Trichinosis, Dermatomyositis, and Discoid Lupus Erythematosus. Color slides will be shown.

Dr. Mopper is a graduate of the University of Georgia and the Medical College of Georgia. He did his residency in Dermatology at Wayne University

in Detroit, Michigan. He is a past president of the Detroit Dermatological Society and a member of the Mexican Dermatological Society and a past lecturer.

Dr. Mopper is a Clinical Associate Professor of Dermatology at Wayne University Medical College. He is a Fellow of the American College of Physicians.



JOHN A. KIRKPATRICK, M.D.

Philadelphia, Pennsylvania

JOHN A. KIRKPATRICK, JR., M.D. will present a post graduate course to the Radiology Section Meeting entitled "The Differential Diagnosis of Certain Skeletal Abnormalities Encountered in Pediatric Radiology" at 2:30 P.M., Sunday, May 6. A short precis follows:

During the pediatric years and particularly during infancy, the differential diagnosis of skeletal lesions will of necessity be large. The paper will emphasize those congenital, metabolic and traumatic abnormalities that must be differentiated one from the other and from variations of the normal. Because bone is growing during this age period there are certain "sign posts" that one can utilize in the differential diagnosis that are not present during adult life when longitudinal bone growth has ceased.

On Monday, May 7, at 9:30 A.M., Dr. Kirkpatrick will present to the Radiology, Orthopedics and Pathology Joint Section Meeting a paper entitled "Post mortem Roentgen Examination of the Skeleton," a summary of which follows:

Postmortem Roentgen Examination of the Skeleton.

Postmortem roentgen examination of the skeleton is a valuable adjunct to the usual postmortem study. Dissection of the skeleton is limited and many lesions that will be apparent radiographically may not be discovered during routine dissection. Particularly in young infants, the earliest stages of congenital abnormalities of bone may be discovered and the localization of lesions of the skeleton radiographically will permit the pathologist to take appropriate tissue for histologic study. The examination is of teaching value as it allows correlation of pre-and-postmortem film studies with gross morphologic and histologic studies.

Dr. Kirkpatrick received his B.S. degree from Franklin and Marshall College in Lancaster, Pennsylvania and his M.D. degree from Temple University School of Medicine in Philadelphia. He did his

internship at York Hospital in York, Pennsylvania and his residency in Radiology at Temple University Hospital. He is certified by the American Board of Radiology.

Dr. Kirkpatrick is the radiologist at St. Christopher's Hospital for Children in Philadelphia and at Children's Heart Hospital also in Philadelphia. He is an Associate Professor of Radiology at Temple Medical School at St. Christopher's Hospital for Children and is Attending Radiologist at the Veterans Administration Hospital in Philadelphia.



CHARLES D. CREEVY, M.D.

Minneapolis, Minnesota

CHARLES D. CREEVY, M.D., will present a paper "The Significance of Urinary Infection in Childhood" to the Obstetrics, Urology, Pediatric and Surgery Joint Section at 9:40 A.M. on Monday, May 7. The following is a precis of that paper:

It is the author's intention to emphasize in every possible way the potential seriousness of evidence of urinary infection in an infant or young child and, particularly, to point out that every child in whom a valid diagnosis of infection of the urinary tract has been made (this requires a catheterized specimen in the female and a voided specimen after retraction and cleansing of the foreskin in the male) should have at the very least an excretory urogram and an accurate measurement of the residual urine. At a place like the University Hospital we see a great many patients whose outlook would have been quite different had this attitude been followed, instead of trying a variety of drugs and investigating the urinary tract for the exclusion of serious lesions only after a long period of delay and ineffectual treatment.

"The Prostate Gland in General Practice" will be presented by Dr. Creevy at 10:00 A.M. Tuesday, May 8 at the General Session of GP Day Meeting. His precis is as follows:

It is proposed to discuss primarily the problems of what to do about the patient with mild prostatism; when an operation is indicated; when it becomes imperative; together with a brief summary of the diagnosis and treatment of carcinoma of the prostate where the role of biopsy and measurements of the acid phosphatase will be emphasized.

Dr. Creevy received his B.S., M.B., M.D., M.S., and Ph.D. degrees from the University of Minnesota.

He did his internship at Lane Hospital in San Francisco, California. He has been a professor of Surgery (Urology) since 1937 and Assistant dean of the Medical School from 1939-1944 at the University of Minnesota. At present he is the director of the Division of Urology at the University of Minnesota.

He is a member of the American Association of G.U. Surgeons, American Urological Association, Clinical Society of G.U. Surgeons and Uro-Surgeons.



JOSEPH W. PEABODY, M.D.

Washington, D.C.

JOSEPH W. PEABODY, M.D. will present to the Chest, Medicine and Psychiatry Joint Section Meeting, a paper entitled "The Many Disguises of Bronchial Carcinoma" at 10:00 A.M., Monday, May 7. A precis of that paper follows:

Too often, it is true, the inherent biological behavior of malignant bronchial tumors precludes their cure regardless of how early their presence is suspected. Much more important but less well appreciated, however, is the fact that for a significant segment of bronchial carcinomas the decisive factor in their cure is the stage at which surgical resection is applied. If detected and operated early, the chance for cure is good; if overlooked or neglected, the opportunity for cure is poor. An awareness, therefore, that certain innocuous looking pulmonary lesions may in fact represent primary carcinomas of the lung, is of the utmost importance.

In this presentation (1) the many clinical and roentgenographic disguises of bronchial carcinoma will be illustrated. (2) The value of various radiographic techniques for differentiating between benign and malignant pulmonary lesions will be emphasized. (3) That prompt surgical intervention can in many instances provide excellent survivorship will be shown, perhaps best illustrated by a personal series of 100 consecutive selected cases of bronchial carcinoma, over 60 per cent of whom are surviving in good apparent health over five years following operation.

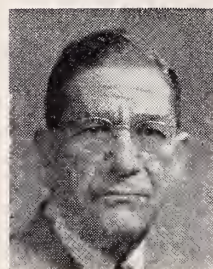
Dr. Peabody will also present a paper, "Recognition and Management of Easily Correctible Congenital Cardiac Lesions" at 3:45 P.M., Tuesday, May 8, to the Medicine, Chest and Diabetes Joint Section Meeting. The following is a synopsis of that paper:

Over the past decade so much attention has been focused on the difficulties of diagnosis and the complexities of surgical correction of the more involved cardiac lesions, that some physicians tend to lose sight of the fact that there are many congenital cardiac lesions that can be readily diag-

nosed and then safely and oftentimes rather simply corrected by various surgical methods.

This paper will deal only with those lesions that can be corrected without utilizing cardiopulmonary bypass. An attempt will be made to simplify wherever possible the diagnostic criteria for each of these various defects and to illustrate the relative ease and safety with which surgery can be carried out.

Dr. Peabody is Assistant Clinical Professor of Thoracic Surgery, Georgetown University School of Medicine, Senior attending Thoracic Surgeon, Washington Hospital Center and Suburban Hospital, Junior Associate in Thoracic and Cardiovascular Surgery, Children's Hospital, and Lecturer in Thoracic Surgery, National Naval Medical Center. He is a diplomate of the American Boards of General and Thoracic Surgery and a Fellow of the American College of Surgeons and American Association for Thoracic Surgery. Dr. Peabody is Associate Editor of DISEASES OF THE CHEST.



ALVAN L. BARACH, M.D.

New York, New York

ALVAN L. BARACH, M.D., will present a paper entitled "Pulmonary Emphysema: Pathophysiology and Practical Appraisal of Function" at 10:40 A.M., Monday, May 7 before the Chest, Diabetes, Medicine and Psychiatry Joint Section Meeting. The following is a precis of his paper:

The disturbance in function in patients with diffuse obstructive pulmonary emphysema will be presented with special reference to those tests which provide information concerning the treatment of the individual case. The effect of physiologically directed procedures on the minute volume of respiration will be demonstrated, including the response to posture, diaphragmatic respiration, oxygen inhalation and other measures.

Dr. Barach will also present a paper to the Medicine, Chest and Diabetes Joint Section Meeting entitled "Chronic Pulmonary Emphysema—Clinical Management" at 3:15 P.M. on Tuesday, May 8. A summary of that paper follows:

In addition to symptomatic use of bronchodilator therapy a regimen of rehabilitation of physical fitness will be presented. Special emphasis will be given to techniques of restoring the function of the diaphragm and to employment of an oxygen walking program to restore exercise capacity. The indication for administration of steroids and allied pharmacologic agents will be discussed.

Dr. Barach is a graduate of the College of the City of New York and Columbia's College of Physicians and Surgeons. He did his internship at Presbyterian Hospital in New York City. Dr. Barach began his studies on respiratory physiology and their application to treatment of diseases of the chest at the Harvard Medical School in 1920. Since 1922 these studies were continued at the Presbyterian Hospital and the College of Physicians and Surgeons, Columbia University, where, at the present time, he is Consultant in Medicine and Clinical Professor of Medicine Emeritus. Also he is the president of the Research and Education Foundation and chairman of the Council on Research of the American College of Chest Physicians.

His most recent award was the Gold Medal received from the American College of Chest Physicians in 1961. Dr. Barach is a member of the American College of Physicians, the Association of American Physicians, the American Academy of Allergy, the Trudeau Society and is a Fellow of the American College of Chest Physicians.



T. A. WATTERS, M.D.

Metairie, Louisiana

T. A. WATTERS, M.D. will present a paper entitled "Depressions in Disguise" at 9:20 A.M., Monday, May 7, to the Chest, Diabetes, Medicine and Psychiatry Joint Section Meeting. The following is a brief precis:

Depressions occur with high frequency, often are masked by physical phenomena, other times by psychological. They may simulate many kinds of disorders. Early detection by clinician spares a patient unnecessary suffering and expense.

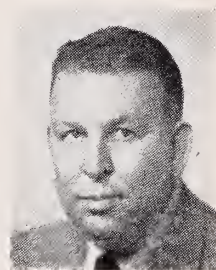
On Tuesday, May 8, at 3:30 he will present "The General Practitioner and the Psychiatric Patient" to the General Practice and Psychiatry Joint Section Meeting.

The author will review his program of teaching non-psychiatric physicians during the past eight years, pointing up practical aspects of the general practitioner's relationship with psychiatric patients, the extent of treatment possibilities, the matter of referral and the cooperative work with the psychiatrist when needed.

Dr. Watters graduated from Tulane Medical School and served two years rotating internship at Charity Hospital in New Orleans. Then he did special work in neurology, neurosurgery and psychiatry

at the Neurological Institute, Columbia Medical Center in New York. Later he undertook advanced work in psychiatry at the Henry Phipps Clinic at Johns Hopkins Hospital in Baltimore.

He is Consultant Neuro Psychiatrist to the Texas Company and the Illinois Central Railway. Dr. Watters is a Clinical Professor of Psychiatry at the Louisiana State University Medical School where he does both undergraduate and postgraduate teaching. He also conducts courses in psychiatry for three groups of general practitioners in New Orleans as well as to a group of clergymen.



JOSEPH FARRINGTON, M.D.

Jacksonville, Florida

JOSEPH FARRINGTON, M.D. will present a paper, "Misconceptions Concerning Dermatology" on Sunday, May 6, at 2:30 before the Dermatology and EENT Joint Section Meeting. A short precis of that paper follows:

Dermatological disorders comprise an estimated ten to 15 per cent of every day medical practice. Certain misconceptions concerning dermatology are held by a considerable proportion of the laity, by some of our nondermatologist colleagues, and perhaps even specialists in dermatology. Erroneous beliefs have been encountered with patients, doctors, and various medical legislative groups. Misconceptions, therefore, are so widespread and so damaging that attempts should be made to correct them. Deficient or inaccurate knowledge about skin diseases has become more serious since the introduction of new drugs. The indiscriminate or improper use of these drugs in dermatology may not only be expensive but may unnecessarily prolong disease and in some cases be hazardous. Case histories with photographic illustrations are selected to refute or correct these erroneous beliefs and by their uniqueness to arouse the interest of other dermatologists as well.

Dr. Farrington received his B.S.C. degree from Duke University and his B.M. and M.D. degrees from the University of Cincinnati. He did his internship at Conemaugh Valley Memorial Hospital in Johnstown, Pennsylvania.

He is certified by the Board of Dermatology and Syphilology. Dr. Farrington is chief of Dermatology at St. Lukes Hospital and Associate Dermatologist at the Duval Medical Center in Jacksonville. He is a member of the North American Clinical Dermatology Society and the International Society of Tropical Dermatology.



JOSEPH H. DAVIS, M.D.

Miami, Florida

JOSEPH H. DAVIS, M.D., will present a paper entitled "Bodies Recovered from Water" at the Medical-Legal Workshop at 11:15 A.M. on Wednesday, May 9. A short precis follows:

The proper investigation of the circumstances surrounding a body recovered from the water requires a most astute and thorough investigation by the pathologist examining the body. He must not only concern himself with post mortem examination but must be thoroughly associated with all phases of the investigation pertaining to the incident. The true circumstances may be appreciated only by an intelligent evaluation of all facts by the experienced medical examiner.

Dr. Davis was graduated from the Long Island College of Medicine and interned at the University of California Hospital in San Francisco, California. He has worked with the U. S. Public Health Service and was an instructor in Pathology at the Louisiana State University, School of Medicine.

At the present he is Chief Medical Examiner for the Office of the Medical Examiner, Dade County, Florida and is a professor of Legal Medicine at the University of Miami, School of Medicine, Miami, Florida.

He is a member of the College of American Pathologists, National Board of Medical Examiners, Forensic Pathology, American Board of Pathology and a diplomate of the American Board of Pathology.



ABE MICKAL, M.D.

New Orleans, Louisiana

ABE MICKAL, M.D. will present at 9:00 A.M., Monday, May 7, a paper, "Infected Abortions" to the Obstetrics, Urology, Pediatric and Surgery Joint Section Meeting. A precis of that paper follows:

This paper deals with 290 cases treated at Charity Hospital at New Orleans. The pathogenesis and clinical courses of these infected cases are pre-

sented as well as the complications most usually associated with this condition. The management on the L.S.U. service is discussed and the results reviewed. A comparison is made between those cases treated conservatively and those which require more aggressive management. Endotoxic shock as a major complication in infected abortion is discussed.

The Obstetric Section Meeting will hear Dr. Mickal at 2:30, Tuesday May 8, deliver a paper on "Management of Gynecological Malignancies on the L.S.U. Obstetrical and Gynecological Service." A summary of that paper follows:

In 1959 the Department of Gynecology at L.S.U. collaborated with the Department of Radiology at Charity Hospital and undertook a study of the management of gynecological malignancies on the L.S.U. service. Interdepartmental staging of all lesions is done by the two services during joint weekly conferences. All patients in this study are consecutive admissions with coding of charts. It is the purpose of this collaborative effort to evaluate the results of surgery and radiation in a comparable series of cases. The projected aims and method of management are discussed.

Dr. Mickal received his B.S. and M.D. degrees from Louisiana State University and served his internship at Touro Infirmary in New Orleans. He served his residency at the L. S. U. Service Obstetrics and Gynecology at Charity Hospital in New Orleans. At the present Dr. Mickal is Obstetrician and Gynecologist-in-Chief, L.S.U. Unit and Senior Visiting Surgeon for Charity Hospital of Louisiana in New Orleans, Consultant Obstetrician and Gynecologist at Lafayette Charity Hospital in Lafayette, Louisiana and at the Lake Charles Charity Hospital in Lake Charles, Louisiana. He is a Professor and Head of the Department of Obstetrics and Gynecology at L.S.U. School of Medicine in New Orleans.

Dr. Mickal is a diplomate of the American Board of Obstetrics and Gynecology, fellow in the American College of Surgeons and a member of the American College of Obstetrics and Gynecology.



GEORGE W. N. EGGERS, M.D.

Galveston, Texas

GEOERGE W. N. EGGERS, M.D., will present to the Orthopedic Section Meeting at 2:30 P.M. Sunday, May 6, a paper, "Fractures of the Tibial Shaft." A short precis follows:

The presentation will approve closed reduction as the method of choice of treatment of fractures

of the tibial shaft. The indications for open reduction will be considered the principles of treatment presented. About 85 per cent of fractures unite and the evaluation of method is in the uncertain 15 per cent of fractures treated.

The approach to the infected fracture of the tibial shaft will be considered and some of the more difficult fractures in the leg area.

On Monday, May 7, at 9:00 A.M. Dr. Eggers will present a paper entitled "Fibrous Bone Lesions, Including Fibrous Dysplasia" to the Radiology, Orthopedics and Pathology Joint Section Meeting. The following is a brief summary:

The consideration of fibrous benign lesions of bone limited or diffused in character will be presented. The pathology, treatment and diagnosis of fibrous lesions will be considered.

Dr. Eggers received his B.A. degree from Rice Institute and his M.D. from the University of Texas School of Medicine.

At the present he is the Medical Director of the School of Physical Therapy at the University of Texas Medical Branch and is a professor of Orthopedic Surgery and Orthopedic Surgeon-in-Chief of the Medical Branch Hospitals at the University of Texas. He is Orthopedic Consultant to the U. S. Public Health Service Hospital in Galveston, the Brooke General Hospital in Fort Sam Houston, Moody State School for Cerebral Palsied Children in Galveston, and U. S. Air Force Hospital at Lackland Air Force Base. He is Visiting Orthopedist for St. Mary's Infirmary in Galveston and Cook Memorial Hospital in La Marque.

Dr. Eggers is certified by the American Board of Orthopaedic Surgery, a Fellow in the American College of Surgeons, a member of the American Orthopaedic Association, and the American International Society of Orthopaedic Surgery and Traumatology. He is Past Chief-of-Staff of the University of Texas Medical Branch Hospitals, Past President of the American Board of Orthopaedic Surgery (2nd term), Past President of the American Academy for Cerebral Palsy and President-Elect of the American Orthopaedic Association.

PAUL W. SEARLES, M.D.

Chicago, Illinois



PAUL W. SEARLES, M.D. will present a paper to the Anesthesiology Section on "Selection of Anesthetic Agents and Techniques," at 2:30 P.M.,

Sunday, May 6. A short synopsis follows:

The three persons involved in the choice of anesthesia are the patient, the surgeon, and the anesthesiologist. Given his choice of anesthesia and assured of safety, the patient is influenced by considerations of comfort and the current fashion. The surgeon generally is swayed by past experiences with a particular agent or an individual anesthesiologist. The anesthesiologist must consider the wishes of the patient and the surgeon, but he must on his own decide what can be done safely in a given case and give adequate reasons for his decision.

The ideal anesthetic has yet to be found. It is significant, however, that most of the stringent conditions are fulfilled today, not by the use of one agent alone, but by combining two or more available agents. This "combined" or "balanced" anesthesia usually enables the operation to proceed smoothly while the patient is kept in a very light plane of anesthesia. Thus the body's physiological state is kept as normal as possible during the operation and the effects of the anesthesia do not compound the danger of the post-operative period. In reality, the combining of small increments of agents, using the best properties of each, when done with reason and restraint, makes the administration of anesthesia considerably simpler, usually safer, and more often than not makes it more efficient.

Dr. Searles received his B.S. from the University of Minnesota and his M.B., M.D. and M.S. from the University of Minnesota Medical School. He did his internship at Hackensack General Hospital and his residency at the Mayo Clinic. He has been active in research in temperature and blood changes, both in laboratory and clinically for the last 28 years.

He is a past Director and Secretary and Chairman of the American College of Anesthesiologists and past president of the New York Society of Anesthesiologists. He is certified by the American Board of Anesthesiology and the American College of Anesthesiology. He is a member of the Illinois Society of Anesthesiologists and the American Society of Anesthesiologists.

CHARLES S. PETTY, M.D.

Baltimore, Maryland



CHARLES S. PETTY, M.D. will present a paper, "Burned Bodies" to the Medical-Legal Workshop, at 9:00 A.M., Wednesday, May 9. A brief precis of that paper follows:

The badly burned body is a subject of great interest to the forensic pathologist. Burned bodies

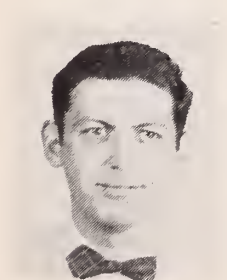
present an unusual problem in regard to identification and the true cause of death.

Insofar as identification is concerned, the severely burned body may not even resemble human remains. Not only is positive identification of the individual rendered difficult, but even preliminary identification procedures such as sex, age and body size may be extremely difficult. Because of such difficulties, many pathologists fail to appreciate the *opportunities* that a burned body actually presents. By appropriate techniques the remains can be sexed, an estimation of age and color can very often be quite accurate, and by means of forensic immunology and other laboratory procedures the body may be rather precisely characterized.

The burned body presents a second perplexing problem in regard to cause of death. It may be of the utmost importance to decide whether the body was alive before the burns were incurred; whether death was due to the fire or not; whether the victim was assaulted before the fire; and, finally, whether the victim was murdered and the fire was the result of an endeavor to cover the tracks of the murderer. Again, by examination of the charred remains, answers to this problem with its numerous complex ramifications may be possible.

Dr. Charles S. Petty received his M.S. Degree in Physiology at the University of Washington, then his M.D. Degree at Harvard Medical School. Following this, he interned at the Mary Imogene Bassett Hospital in Cooperstown, New York. Three years of residency training in Pathology were spent in Boston. He was a member of the Department of Pathology, Louisiana State University School of Medicine for three years. During this period of time he was a pathologist to the Office of the Coroner, Parish of Orleans.

Since 1958, he has been Assistant Medical Examiner for the State of Maryland. He holds faculty positions at the University of Maryland School of Medicine and Johns Hopkins University School of Hygiene and Public Health. Dr. Petty is a Fellow of the American Academy of Forensic Sciences and a Fellow of the American College of Physicians.



MALCOLM A. HOLLIDAY, M.D.

Pittsburgh, Pennsylvania

MALCOLM A. HOLLIDAY, M.D. will present to the Pediatrics and Surgery Joint Section Meeting at 3:30 p.m., Sunday, May 6, a paper entitled "RBC Osmotic Fragility and Hypernatremia—An Unexpected Relationship." The following is a

brief synopsis:

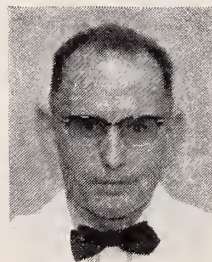
The diagnosis of hypernatremia may arise as an unexpected laboratory finding. More often certain aspects of both history and physical findings give a clue. The effect of hypernatremia to increase red cell osmotic fragility is a useful screening test for hypernatremia, and may pick out unsuspected cases. The changes in red cells also teach us a lesson in the physiology of hypernatremia that underlines some of the hazards of treatment.

Dr. Holliday will also present a paper "Renal Failure and the Importance of Some Little Things" to the Obstetrics, Urology, Pediatric and Surgery Joint Section, at 10:00 a.m., Monday, May 7. A short precis follows:

Acute renal failure due to noxious agents can be averted or its severity lessened by the careful expansion of extracellular fluid to its normal volume. Once developed, the administration of water must be parsimoniously and carefully planned. Salt at this time usually is bad and only a few situations require it. Though the care of such patients requires the best possible facilities—the practitioner can make important contributions in the first few hours of management.

Dr. Holliday received his B.A. and M.D. degrees from the University of Virginia. He served his internship at Children's Hospital in Boston. He had a Research Fellowship in Pediatrics at Yale University, Department of Pediatrics and at Harvard Medical School (Children's Hospital). He has been Assistant Professor in the Department of Pediatrics at Indiana University Medical Center and the University of Pittsburgh School of Medicine, where he is now an Associate Professor.

He is a member of the American Federation for Clinical Research and the Society for Pediatric Research.



LENT C. JOHNSON, M.D.

Washington, D.C.

LENT C. JOHNSON, M.D. will present to the Radiology, Orthopedics and Pathology Joint Section Meeting, at 10:00 A.M., Monday, May, 7, a paper, "Joint Remodeling and Kinetics of Osteoarthritis. The following is a brief precis:

A concept of joint modeling and its relation to osteoarthritis evolved from study of several thousand whole bone and joint sections in all types of joint disease and in the aging subject is outlined in this presentation.

Most of the facts have been well documented in the literature, but the interpretations have varied.

Studies on large animals of pure breed, sacrificed serially, are needed to verify or modify the interpretations of articular function raised by this discussion. A most important need is a method for labeling cartilage visibly and permanently (as alizarin label bone) to permit quantitative studies of cartilage turnover rates and of remodeling. Serial x-rays of cattle joints, as they develop osteoarthritis, will go far to clarify the interplay of remodeling and degeneration in the kinetics of joint disease. Comparative studies of foreleg and hindleg degenerative arthroses in race horses (where the forelegs are subjected to explosive bursts of weight-bearing while the hindlegs act as drivers) should help to unravel the role of mechanical factors in remodeling and degeneration.

Dr. Johnson received his B.S. and M.D. degree from the University of Chicago and did post graduate training in surgery, medicine and pathology at the University of Chicago and in Boston. He has been with the Armed Forces Institute of Pathology since 1942.

with that obtained by the law-enforcement authorities from their on-the-scene and other investigative activities.

Dr. Adelson graduated from Harvard in 1935, magna cum laude and received his M.D. degree from Tufts College Medical School in 1939. His internship and residency were served at John J. McCook Memorial Hospital in Hartford, Connecticut. He received a Fellowship in Legal Medicine from the Department of Legal Medicine, Harvard Medical School in 1950. Dr. Adelson is Certified by the American Board of Pathology in Pathology Anatomy and Clinical Pathology and Forensic Pathology. His present position is Chief Deputy Coroner for Cuyahoga County Coroner's office in Cleveland. He is also an associate professor of Forensic Pathology at Western Reserve School of Medicine in Cleveland. Dr. Adelson has approximately 45 papers published in national and international journals.

LESTER ADELSON, M.D.

Cleveland, Ohio



LESTER ADELSON, M.D., will present a paper entitled "Traumatic Injuries in Medico-Legal Cases" at the Medical-Legal Workshop at 2:30 P.M. on Wednesday, May 9. The following is a short precis of that paper:

The majority of deaths which come to the attention of the modern medico-legal investigating office are made up of persons who either die suddenly and unexpectedly from apparently natural causes or who die under such circumstances as to implicate known or suspected injury arising from homicidal, suicidal or accidental incidents. It is vital to realize that the seeming absence of external injury in persons dying of putative natural disease does not preclude the presence of internal trauma of lethal nature. Conversely, the presence of abundant external evidence of injury in no way establishes that death arose from some type of violence. The injuries may all be quite superficial, and death may well have resulted from natural disease. Moreover, it is essential to differentiate between ante-mortem and post-mortem injuries for the proper reconstruction of the events leading up to death and for the correct interpretation of the overall situation.

The presentation will consider a broad variety of deaths arising from a wide variety of trauma, exemplifying the theses noted above and will be illustrated by colored slides depicting the different types of lesions. Emphasis will be placed upon the necessity of complete autopsy study and correlation of the anatomic data with other laboratory findings, and ultimately collating this information

HUGH B. LYNN, M.D.

Rochester, Minnesota



HUGH B. LYNN, M.D. will present a paper, "The Management of Acute Surgical Problems in Children" at 4:15 P.M., Sunday, May 6, to the Pediatrics and Surgery Joint Section Meeting. A precis of that paper follows:

The optimal age for elective surgical procedures is a relatively controversial subject. An attempt will be made to outline the ages at which most of the common surgical procedures are done by the author and a discussion for the justification of these times.

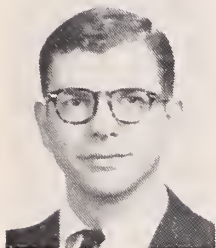
Also Dr. Lynn will present a paper entitled "The Optimal Age for Elective Surgery" to the Obstetrics, Urology, Pediatric and Surgery Joint Section Meeting at 9:20 A.M., Monday, May 7. The following is a brief summary:

Every effort will be made to emphasize the minutiae of patient care which make the difference between a successful and an unsuccessful outcome of a surgical procedure. Actual surgical problems of a technical nature will be avoided in order to emphasize the general pre and postoperative management of the acute surgical problem. Any reference to operating room treatment will deal with the support of the patient during surgery.

Dr. Lynn was graduated from Princeton University and Columbia University Medical School. He is certified by the American Board of Surgery and is a member of the Surgical Section of the American

Academy of Pediatrics, the American Academy of Pediatrics and the American College of Surgeons.

At the present Dr. Lynn is an Assistant Professor of Surgery at the Graduate School Mayo Foundation at the University of Minnesota and is Head of a Section of Pediatric Surgery at the Mayo Clinic.



WILLIAM K. JENSON, M.D.

Philadelphia, Pennsylvania

WILLIAM K. JENSON, M.D. will present a paper entitled "Treatment of the Uncomplicated Patient" to the Chest, Diabetes, Medicine and Psychiatry Joint Section Meeting at 11:20 a.m., Monday, May 7. A short precis of that paper follows:

Progress is frequently associated with a temporary sacrifice of simplicity. Diabetes, and its therapy is a good example.

There is a wide variety in diets, there are eight insulins, and a variety of mixtures of insulins from which to choose. There are three oral compounds available commercially which may be employed singly, in combinations or in conjunction with insulin therapy.

Therapy for the individual patient must be selected with a full understanding of diabetes in its broadest sense, and of the properties of the available insulins and oral compounds.

Failure to take advantage of the full treatment of diabetes, or to be satisfied with partial treatment is not enough. To make a severe diabetic appear mild, or to secure adequate control for only a few hours out of each 24, surely permits a harvest of complications.

Diabetes is a chronic life long disease which requires the fullest cooperation between the patient and his physician. Good control can be obtained, not by either alone, but only by combined effort and understanding.

Dr. Jensen will also present a paper to the Medicine, Chest and Diabetes Joint Section Meeting at 2:45 P.M., Tuesday May 8 on "Treatment of Diabetic Acidosis." A brief summary follows:

Diabetic Acidosis is a medical emergency, requiring immediate recognition and treatment.

The diagnosis can be made and confirmed at the bedside, and does not require a long wait for confirmatory laboratory results.

Urine, sugar and acetone of 4+ reaction and a plasma acetone of 4+ are diagnostic.

Initial insulin dose and subsequent insulin doses can be guided accurately by the bedside plasma acetone test.

Adequate fluid and electrolyte therapy are essential.

Dr. Jensen received his A.B. degree from the University of Kansas and his M.D. degree from the Jefferson Medical College of Philadelphia. He did his internship and residency at Pennsylvania Hospital in Philadelphia. He had an American Diabetes Association Fellowship at Guy's Hospital in London, England.

Presently Dr. Jensen is an Instructor in Medicine at the University of Pennsylvania School of Medicine. He is a member of the American Diabetes Association and a Fellow of the College of Physicians of Philadelphia.

VOTING RULES

Bylaws, Chapter V, Election of Officers

SECTION 3, METHOD. The President shall appoint a committee of not less than three Tellers immediately after the close of nominations, who shall have charge of the election. The Secretary shall have prepared in advance an official ballot and an official ballot box, which shall be kept in the custody of the Tellers Committee. One ballot only shall be given to each active voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in the locked ballot box.

The candidates for office receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select by secret ballot the officer from the two candidates having the highest number of votes.

SECTION 4. TIME. Voting shall take place during the hours of the scientific program up to the beginning of the last meeting on the last day of the Annual Session. At that time the Committee of Tellers shall count the ballots and report their findings to the members.

The Program

SATURDAY NIGHT, MAY 5

Social Events

(Not a part of Official Program)

Saturday Night, May 5

NOTE: Make Reservations in Advance with Chairman if possible.

6:00 Georgia Society of Anesthesiologists Social Hour
Boar's Head Inn, 1 North Lincoln Street
R. L. Stone, Savannah, Chairman

SUNDAY MORNING, MAY 6

10:30 Georgia Society of Anesthesiologists Business Meeting

Habersham Room, DeSoto Hotel

PRESIDING

John E. Steinhaus, Atlanta

SUNDAY AFTERNOON, MAY 6

Social Events

(Not a part of Official Program)

Sunday Noon, May 6

NOTE: Make reservations in advance with Chairman if possible.

11:30 Georgia Pediatric Society Luncheon
Gaslight Room, DeSoto Hotel
Milton Mazo, Savannah, Chairman

12:00 Georgia Society of Dermatologists Luncheon
Habersham Room, DeSoto Hotel
Vincent J. Cirincione, Savannah, Chairman

2:00 MAG General Business Session

(ALL MAG AND AUXILIARY MEMBERS AND GUESTS INVITED)

DeSoto Ballroom, DeSoto Hotel

PRESIDING

Fred H. Simonton, President

NOMINATIONS OF OFFICERS AND COUNCILORS

(Announcement of Tellers Committee)

President-Elect

First Vice President

Second Vice President

AMA Delegate (Term beginning January 1, 1963)

AMA Delegate (Term beginning January 1, 1963)

AMA Alternate Delegate (Term beginning January 1, 1963)

AMA Alternate Delegate (Term beginning January 1, 1963)

Fifth District Councilor (To serve until 1965)

Fifth District Vice Councilor (To serve until 1965)

Sixth District Councilor (To serve until 1965)

Sixth District Vice Councilor (To serve until 1965)

Seventh District Councilor (To serve until 1965)

Seventh District Vice Councilor (To serve until 1965)

Eighth District Councilor (To serve until 1965)

Eighth District Vice Councilor (To serve until 1965)

Muscogee County Medical Society Councilor (To serve until 1965)

Muscogee County Medical Society Vice Councilor (To serve until 1965)

NOMINATIONS FOR AWARDS:

GENERAL PRACTITIONER OF THE YEAR AWARD

(To be voted on by the House of Delegates)

HARDMAN AWARD

(To be voted on by the House of Delegates)

2:30 Pediatrics and Surgery Joint Section Meeting

(ALL PHYSICIANS INVITED)

DeSoto Ballroom, DeSoto Hotel

PRESIDING

J. R. Winburn, Jr., Savannah

2:30 RECENT ADVANCES IN PEDIATRIC SURGERY
Richard S. Owings, Augusta

2:30 RBC OSMOTIC FRAGILITY AND
HYPERNATREMIA—AN UNEXPECTED
RELATIONSHIP

Malcolm Holliday, Pittsburg, Pennsylvania

3:30 INTERMISSION — VIEW EXHIBITS

3:45 MANAGEMENT OF THORACIC SURGICAL
EMERGENCIES IN INFANTS

Robert G. Ellison and William E. Laupus,
Augusta

4:15 THE MANAGEMENT OF ACUTE SURGICAL
PROBLEMS IN CHILDREN

Hugh B. Lynn, Rochester, Minnesota

2:30 Dermatology and EENT Joint Section Meeting

(ALL PHYSICIANS INVITED)

Georgian Room, DeSoto Hotel

PRESIDING

Vincent J. Cirincione, Savannah

2:30 MISCONCEPTIONS CONCERNING
DERMATOLOGY

Joseph Farrington, Jacksonville, Florida

- 3:05 TRAUMATIC HYPHEMA
Franklyn P. Bousquet, Jr., Savannah
- 3:20 CORRECTION OF RECEDED CHIN
COMBINED WITH RHINOPLASTY
Frank Hoffman, Savannah
- 3:40 DIAGNOSTIC SIGNIFICANCE OF THE EYELIDS
Coleman Mopper, Detroit, Michigan
- 4:15 MANAGEMENT OF EPITHELIOMAS ABOUT
THE EYES
MODERATOR
Vincent J. Cirincione, Savannah
- PANEL
Joseph Farrington, Jacksonville, Florida
Coleman Mopper, Detroit, Michigan
W. W. Buckhaults, Savannah
Franklyn Bousquet, Savannah

2:30 Anesthesiology Section

(ALL PHYSICIANS INVITED)

Cotillion Room, DeSoto Hotel

PRESIDING

R. L. Stone, Savannah

- 2:30 SELECTION OF ANESTHETIC AGENTS AND
TECHNIQUES
Paul W. Searles, Chicago, Illinois
- 3:30 PENTHRANE (Movie)
Norman Wheeler, North Chicago, Illinois
- 4:00 SYMPOSIUM ON FLUORINATED AGENTS
MODERATOR
R. L. Stone, Savannah
- PANEL
Paul W. Searles, Chicago
John E. Steinhaus, Atlanta
P. P. Volpitto, Augusta
- 5:15 FLAMMABILITY RANGES WITH FLUOROMAR
ANESTHESIA
Z. W. Gramling and P. P. Volpitto,
Augusta

2:30 Orthopedic Section Meeting

(ALL PHYSICIANS INVITED)

Habersham Room, DeSoto Hotel

PRESIDING

James Funk, Atlanta

- 2:30 FRACTURES OF THE TIBIAL SHAFT
George W. N. Eggers, Galveston, Texas
- 3:00 SCOLIOSIS TROUBLE
Darius Flinchum, Atlanta
- 3:30 OPEN REDUCTION OF ACETABULAR
FRACTURES
Waldo Floyd, Macon
- 4:00 VERTEBRAL FRACTURES: OLD OR NEW
Ernest G. Edwards, Savannah
- 4:30 FIRST LUMBAR ROOT SYNDROME
L. E. Dickey and James M. Wells, Jr., Macon

2:30 Radiology Section Meeting

(ALL PHYSICIANS INVITED)

Camellia Room, Manger Hotel

PRESIDING

Robert Drane, Savannah

- 2:30 POSTGRADUATE COURSE: THE DIFFERENTIAL
DIAGNOSIS OF CERTAIN SKELETAL
ABNORMALITIES ENCOUNTERED IN
PEDIATRIC RADIOLOGY
John A. Kirkpatrick, Jr., Philadelphia,
Pennsylvania
- 4:00 EARLY RADIOLOGY IN SAVANNAH, GEORGIA
David Robinson, Savannah
- 4:15 FILM INTERPRETATION SESSION
MODERATOR:
Harry H. McGee, Jr., Savannah
- PANEL
(To be announced)

4:45 MAG Delegates Registration

DeSoto Ballroom Entrance, DeSoto Hotel

5:00 House of Delegates Meeting

DeSoto Ballroom, DeSoto Hotel

PRESIDING

J. Frank Walker, Atlanta,

Speaker of the House

- 5:05 ORDER OF BUSINESS (See Delegates Hand-
book)
REPORT OF PRESIDENT WOMAN'S
AUXILIARY TO MAG
Mrs. A. Worth Hobby, Atlanta
- 5:45 THE TRIANGLE OF MEDICINE—RESEARCH,
EDUCATION AND PATIENT CARE
Hugh H. Hussey, Washington, D. C.,
Chairman, Board of Trustees,
American Medical Association

SUNDAY EVENING, MAY 6

6:30 House of Delegates and Exhibitors Social Hour

Gold Room, DeSoto Hotel

Changes are always made after the printing
of the program in the Journal. Be sure to
check the Official Program for these changes.

Social Events

(Not a part of Official Program)

Sunday Night, May 6

NOTE: Make reservations in advance with Chairman if possible.

- 6:30 Georgia Society of Internal Medicine Dinner
Habersham Room, DeSoto Hotel
Fenwick Nichols, Savannah, Chairman
- 6:30 Georgia Radiological Society Dinner
Veranda Room, Manger Hotel
David Robinson, Savannah, Chairman
- 6:30 Georgia Orthopedic Society Dinner
Residence of Ernest G. Edwards, Jr.
1212 Sweetbriar Circle
T. A. Amburgey, Savannah, Chairman
- 7:00 Georgia Society of Ophthalmology and
Otolaryngology Dinner
Georgian Room, DeSoto Hotel
W. W. Buckhaults, Savannah, Chairman
- 7:30 Georgia Pediatric Society Dinner
DeSoto Lounge, DeSoto Hotel
Milton Mazo, Savannah, Chairman
- 6:00 Georgia Psychiatric Association Social Hour
and Dinner
Pirates House, 20 E. Broad Street
A. H. Center, Savannah, Chairman
- 8:00 Georgia Psychiatric Association Business
Meeting
Pirates House, 20 E. Broad Street
PRESIDING
E. James McCranie, Augusta, President

MONDAY MORNING, MAY 7

8:00 MAG Reference Committees

- 8:00 REFERENCE COMMITTEE NO. 1
Room 400, DeSoto Hotel
- 8:00 REFERENCE COMMITTEE NO. 2
Room 450, DeSoto Hotel
- 8:00 REFERENCE COMMITTEE NO. 3
Red Surrey Lounge (basement),
DeSoto Hotel

9:00 Chest, Diabetes, Medicine and Psychiatry Joint Section Meeting

(ALL PHYSICIANS INVITED)

DeSoto Ballroom, DeSoto Hotel

PRESIDING

Dan Willoughby, Savannah

- 9:00 IDIOPATHIC PERICARDITIS — A CONTINUING
DIAGNOSTIC PROBLEM

Frederick S. Armstrong, U. S. Army
Hospital, Fort Gordon, Georgia

- 9:20 DEPRESSIONS IN DISGUISE

T. A. Watters, Metairie, Louisiana

- 10:00 THE MANY DISGUISES OF BRONCHIAL
CARCINOMA

Joseph W. Peabody, Jr., Washington, D. C.

- 10:40 PULMONARY EMPHYSEMA:
PATHOPHYSIOLOGY AND PRACTICAL
APPRAISAL OF FUNCTION
Alvan L. Barach, New York, New York
- 11:20 TREATMENT OF THE UNCOMPLICATED
DIABETIC PATIENT
William K. Jenson, Philadelphia,
Pennsylvania

9:00 Obstetrics, Urology, Pediatrics and Surgery Joint Section Meeting

(ALL PHYSICIANS INVITED)

Cotillion Room, DeSoto Hotel

PRESIDING

Henry Frech, Savannah

- 9:00 INFECTED ABORTIONS

Abe Mickal, New Orleans, Louisiana

- 9:20 THE OPTIMAL AGE FOR ELECTIVE
SURGICAL PROCEDURES

Hugh B. Lynn, Rochester, Minnesota

- 9:40 THE SIGNIFICANCE OF URINARY INFECTION
IN CHILDHOOD

C. D. Creevy, Minneapolis, Minnesota

- 10:00 RENAL FAILURE AND THE IMPORTANCE OF
SOME LITTLE THINGS

Malcolm Holliday, Pittsburgh, Pennsylvania

- 10:30 PROBLEMS AND COMPLICATIONS OF
PEDIATRIC SURGERY

MODERATOR:

Richard S. Owings, Augusta

PANEL

Abe Mickal, New Orleans, Louisiana

Hugh B. Lynn, Rochester, Minnesota

C. D. Creevy, Minneapolis, Minnesota

Malcolm Holliday, Pittsburgh, Pennsylvania

9:00 Radiology, Orthopedics and Pathology Joint Section Meeting

(ALL PHYSICIANS INVITED)

Georgian Room, DeSoto Hotel

PRESIDING

M. F. Nunez, Savannah

- 9:00 FIBROUS BONE LESIONS, INCLUDING
FIBROUS DYSPLASIA

George W. N. Eggers, Galveston, Texas

- 9:30 POSTMORTEM ROENTGEN EXAMINATION OF
THE SKELETON

John A. Kirkpatrick, Jr., Philadelphia,
Pennsylvania

- 10:00 JOINT REMODELING AND KINETICS OF
OSTEOARTHRITIS

Lent C. Johnson, Washington, D. C.

- 10:30 PERTINENT FACTORS IN THE DIFFERENTIAL
DIAGNOSIS OF BENIGN AND MALIGNANT
BONE LESIONS

MODERATOR:

Russell Wigh, Augusta

PANEL

George W. N. Eggers, Galveston, Texas

John A. Kirkpatrick, Jr., Philadelphia,
Pennsylvania

Lent C. Johnson, Washington, D. C.

MONDAY AFTERNOON, MAY 7

12:00 MAG General Business Session

(ALL MAG AND AUXILIARY MEMBERS
AND GUESTS INVITED)

DeSoto Ballroom, DeSoto Hotel

PRESIDING

Fred H. Simonton, Chickamauga, President,
Medical Association of Georgia

12:00 INVOCATION

Rev. Ernest Risley, St. John's Episcopal
Church, Savannah

12:05 WELCOME

John Kirk Train, Jr., Savannah, President,
Georgia Medical Society

WELCOME

Honorable Malcolm R. MacLean, Mayor,
City of Savannah

PRESIDING

Linton H. Bishop, Atlanta,
First Vice President

REPORT OF THE PRESIDENTIAL YEAR
1961-1962

Fred H. Simonton, Chickamauga, President

OUR ASSOCIATION FUTURE FOR 1962-1963

Thomas W. Goodwin, Augusta,
President-Elect

Social Events

(Not a part of Official Program)

Monday Noon, May 7

*NOTE: Make reservations in advance with Chair-
man if possible.*

12:30 Georgia Urological Association Luncheon
Oglethorpe Club, 450 Bull Street
Irving Victor, Savannah, Chairman

1:00 Georgia Chapter, American College of
Chest Physicians Luncheon
Chatham Room, DeSoto Hotel
J. L. Alexander, Savannah, Chairman

1:00 Georgia Association of Pathologists Luncheon
Habersham Room, DeSoto Hotel
H. L. Howard, Savannah, Chairman

1:00 Georgia Radiological Society Luncheon &
Business Meeting
Camellia Room, Manger Hotel
David Robinson, Savannah, Chairman

1:00 Georgia Chapter, American College of
Surgeons Luncheon
*Johnny Ganem's Restaurant, 501 Habersham
Street*
J. R. Winburn, Savannah, Chairman

1:00 Georgia Diabetes Association Luncheon
Gaslight Room, DeSoto Hotel
Jules Victor, Savannah, Chairman

1:00 Georgia State Obstetrical and Gynecological
Society Social Hour and Luncheon
Gold Room, DeSoto Hotel
Henry C. Frech, Savannah, Chairman

2:30 MAG Reference Committees

2:30 REFERENCE COMMITTEE NO. 4
Room 400, DeSoto Hotel

2:30 REFERENCE COMMITTEE NO. 5
Room 450, DeSoto Hotel

MONDAY NIGHT, MAY 7

Social Events

(Not a part of Official Program)

Monday Night, May 7

*NOTE: Make reservations in advance with Chairman
if possible.*

6:00 Georgia State Ob-Gyn Society Social Hour
Oglethorpe Club, 450 Bull Street

Henry C. Frech, Savannah, Chairman

6:30 Medical College of Georgia Alumni Social
Hour and Dinner

DeSoto Ballroom, DeSoto Hotel

Emory University Medical Alumni Associa-
tion Hour

(To be announced)

TUESDAY MORNING, MAY 8

9:00 General Session—GP Day Meeting

(ALL PHYSICIANS INVITED)

DeSoto Ballroom, DeSoto Hotel

PRESIDING

Charles E. McArthur, Cordele

9:00 MYXEDEMA AND COMA

George Dillinger, Thomasville

9:20 RECOGNITION OF THORACIC SURGICAL
EMERGENCIES IN INFANTS

William E. Laupus and Robert G. Ellison,
Augusta

10:00 THE PROSTATE GLAND IN GENERAL
PRACTICE

C. D. Creevy, Minneapolis, Minnesota

TUESDAY AFTERNOON, MAY 8

2:30 General Practice and Psychiatry Joint Section Meeting

(ALL PHYSICIANS INVITED)

DeSoto Ballroom, DeSoto Hotel

PRESIDING

A. H. Center, Savannah

2:30 SCIENTISTS, MECHANICS AND HEALERS

Reid Gullatt, Cochran

3:00 CURRENT ROLE OF HYPNOSIS IN MEDICINE

Sheldon B. Cohen, Atlanta

3:30 THE GENERAL PRACTITIONER AND THE
PSYCHIATRIC PATIENT

T. A. Watters, Metairie, Louisiana

2:30 Medicine, Chest and Diabetes Joint Section Meeting

(ALL PHYSICIANS INVITED)

Cotillion Room, DeSoto Hotel

PRESIDING

Mason Robertson, Savannah

- 2:30 COMMON NON-ULCERATIVE CONDITIONS OF THE GASTROINTESTINAL TRACT
James I. Weinberg, Atlanta
- 2:45 TREATMENT OF DIABETIC ACIDOSIS
William K. Jenson, Philadelphia, Pennsylvania
- 3:15 CHRONIC PULMONARY EMPHYSEMA — CLINICAL MANAGEMENT
Alvan L. Barach, New York, New York
- 3:45 RECOGNITION AND MANAGEMENT OF EASILY CORRECTABLE CONGENITAL CARDIAC LESIONS
Joseph W. Peabody, Jr., Washington, D. C.
- 4:15 CURRENT TRENDS IN THE MANAGEMENT OF HYPERTHYROIDISM
Wayne V. Greenberg, Augusta
- 4:30 A PLAN FOR CONCERTED ATTACK ON THE STAPHYLOCOCCUS AUREUS HEMOLYTICUS
Jack C. Norris, Atlanta
- 4:45 CURABLE TYPES OF METABOLIC BONE DISEASE
Thomas Findley, Augusta

2:30 Obstetric Section Meeting

(ALL PHYSICIANS INVITED)

Georgian Room, DeSoto Hotel

PRESIDING

Peter Graffagnino, Columbus

- 2:30 MANAGEMENT OF GYNECOLOGICAL MALIGNANCIES ON THE L.S.U. OBSTETRICAL AND GYNECOLOGICAL SERVICE
Abe Mickal, New Orleans, Louisiana
- 3:00 THE LOCHIA HAS CHANGED
Arthur A. Smith, Atlanta
- 3:30 PROLAPSE OF THE UMBILICAL CORD
Leon Pittman, Atlanta
- 4:00 TRANSVAGINAL PARACERVICAL AND PUDENDAL BLOCK DURING LABOR AND DELIVERY
Joel D. Conner, Augusta
- 4:15 DEMEROL, SCOPOLAMINE AND SPARINE DURING LABOR AND DELIVERY
C. B. Burgstiner, Savannah
- 4:30 SYMPOSIUM ON OBSTETRICAL ANESTHESIA AND ANALGESIA
MODERATOR:
Peter Graffagnino, Savannah
- PANEL:
Abe Mickal, New Orleans, Louisiana
F. P. Zuspan, Augusta
John D. Thompson, Atlanta
W. B. Dashiell, Columbus

WEDNESDAY MORNING, MAY 9

8:30 Medical-Legal Workshop

(BY REGISTRATION FEE ONLY)

Cotillion Room, DeSoto Hotel

PRESIDING

Herman D. Jones, Ph.D., Atlanta

- 9:00 BURNED BODIES
Charles S. Petty, Baltimore, Maryland

- 11:00 INTERMISSION
- 11:15 BODIES RECOVERED FROM WATER
Joseph H. Davis, Miami, Florida
- 12:15 LUNCHEON
- 1:30 BODIES RECOVERED FROM WATER (Continued)
Joseph H. Davis, Miami, Florida
- 2:30 TRAUMATIC INJURIES IN MEDICO-LEGAL CASES
Lester Adelson, Cleveland, Ohio
- 4:30 INTERMISSION
- 4:45 ASPECTS OF GEORGIA POST MORTEM ACT
Herman D. Jones, Ph.D., Atlanta

9:00 House of Delegates Second Meeting

DeSoto Ballroom, DeSoto Hotel

PRESIDING

J. Frank Walker, Atlanta,
Speaker of the House

ORDER OF BUSINESS

(See Delegates Handbook)

11:00 MAG General Business Session

(ALL MAG AND AUXILIARY MEMBERS AND GUESTS INVITED)

DeSoto Ballroom, DeSoto Hotel

PRESIDING

Fred H. Simonton, Chickamauga, President

PRESENTATION OF 50 YEAR CERTIFICATES

Milford B. Hatcher, Macon, Immediate Past President, Medical Association of Georgia

PRESENTATION OF SCIENTIFIC EXHIBIT AWARDS

Edgar Grady, Atlanta, Chairman, Scientific Awards Committee

PRESENTATION OF GENERAL PRACTITIONER OF THE YEAR AWARD

Charles E. McArthur, Cordele, President, Georgia Academy of General Practice

PRESENTATION OF MAG CERTIFICATES OF APPRECIATION

John T. Mauldin, Atlanta, Secretary, Medical Association of Georgia

PRESENTATION OF HARDMAN AWARD

Thomas W. Goodwin, Augusta, President-Elect, Medical Association of Georgia

PRESENTATION OF MAG DISTINGUISHED SERVICE AWARD

Fred H. Simonton, Chickamauga, President, Medical Association of Georgia

SELECTION OF SITE FOR ANNUAL MEETING 1964

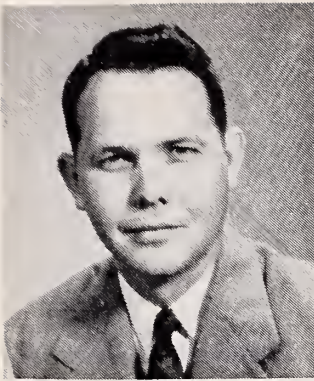
ANNOUNCEMENT OF MAG ELECTION RESULTS

Chairman, Tellers Committee

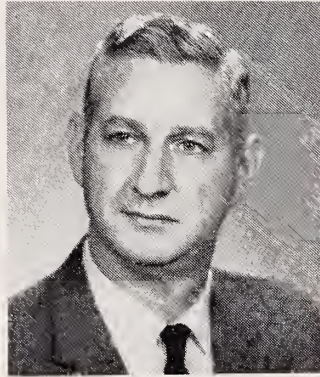
INSTALLATION OF 1962-1963 OFFICERS

Fred H. Simonton, Chickamauga, Immediate Past President, Medical Association of Georgia

ADJOURNMENT OF 108TH ANNUAL SESSION



LINTON H. BISHOP
First Vice President



LEE H. BATTLE
Second Vice President



FRED H. SIMONTON
President

MEDICAL ASSOCIATION OF GEORGIA OFFICERS 1961-1962



THOMAS W. GOODWIN
President-Elect



JOHN T. MAULDIN
Secretary

Medical Association of Georgia

Officers, Committees and Boards

Officers

President, Fred Simonton, Chickamauga (1962)
President-Elect, Thomas W. Goodwin, Augusta (1962)
Immediate Past President, Milford B. Hatcher, Macon (1962)
First Vice President, Linton H. Bishop, Atlanta (1962)
Second Vice President, Lee H. Battle, Rome (1962)
Chairman of Council, George H. Alexander, Forsyth (1962)
Secretary, John T. Mauldin, Atlanta (1963)
Treasurer, John S. Atwater, Atlanta
Speaker of the House, J. Frank Walker, Atlanta (1962)
Vice Speaker of the House, Joseph B. Mercer, Brunswick (1962)

Councilors

District
 1—Charles Bohler, Brooklet (1964)
 2—George Dillinger, Thomasville (1964)
 3—Frank Wilson, Leslie (1964)
 4—Virgil Williams, Griffin (1964)
 5—Floyd Sanders, Decatur (1962)
 6—Wm. Rawlings, Sandersville (1962)
 7—Ralph W. Fowler, Marietta (1962)
 8—F. G. Eldridge, Valdosta (1962)
 9—C. R. Andrews, Canton (1963)
 10—Addison Simpson, Jr., Washington (1963)
 Georgia Medical Society
 Walter Brown, Savannah (1964)
 Richmond County Medical Society
 H. D. Pinson, Augusta (1963)
 Muscogee County Medical Society
 W. P. Jordan, Columbus (1962)
 Bibb County Medical Society
 George Alexander, Forsyth (1963)
 Fulton County Medical Society
 J. G. McDaniel, Atlanta (1963)

Vice Councilors

District
 1—William Simmons, Sylvania (1964)
 2—W. Frank McKemie, Albany (1964)
 3—Robert Martin, Cuthbert (1964)
 4—C. T. Cowart, LaGrange (1964)
 5—Lawrence Matthews, Decatur (1962)
 6—John Bell, Dublin (1962)
 7—Ralph N. Johnson, Rome (1962)
 8—James M. Hicks, Brunswick (1962)
 9—P. T. Scoggins, Commerce (1963)
 10—M. A. Hubert, Athens (1963)
 Georgia Medical Society
 T. A. Peterson, Savannah (1964)
 Richmond County Medical Society
 J. L. Mulherin, Augusta (1963)
 Muscogee County Medical Society
 Luther Wolff, Columbus (1962)
 Bibb County Medical Society
 W. H. M. Weaver, Macon (1963)
 Fulton County Medical Society
 Charles S. Jones, Atlanta (1963)

Delegates to the AMA

Delegate—J. W. Chambers, LaGrange (1964)
 Alternate—George Dillinger, Thomasville (1964)
 Delegate—Henry H. Tift, Macon (1963)
 Alternate—W. G. Elliott, Cuthbert (1963)
 Delegate—Eustace A. Allen, Atlanta (1963)
 Alternate—Thomas A. McGoldrick, Savannah (1963)

ASSOCIATION COMMITTEES

Executive Committee

Fred H. Simonton, Chickamauga, *President* (1962)
 Thomas W. Goodwin, Augusta, *President-Elect* (1962)
 Milford B. Hatcher, Macon, *Immediate Past President* (1962)
 George H. Alexander, Forsyth, *Chairman of Council* (1962)
 John T. Mauldin, Atlanta, *Secretary* (1963)
 J. G. McDaniel, Atlanta
Chairman of Finance (1962)
 Linton H. Bishop, Atlanta,
First Vice President, Ex-officio

Finance Committee

J. G. McDaniel, Atlanta, *Chairman*
 Virgil Williams, Griffin
 Charles R. Andrews, Canton

Professional Conduct Committee

William P. Harbin, Jr., Rome, *Chairman*
 H. D. Allen, Jr., Milledgeville
 W. Bruce Schaefer, Toccoa
 Luther H. Wolff, Columbus
 Milford B. Hatcher, Macon
 Charles S. Jones, Atlanta

Woman's Auxiliary Advisory Committee

Luther H. Wolff, Columbus, *Chairman* (1962)
 Remer Y. Clark, Marietta (1962)
 W. G. Elliott, Cuthbert (1963)
 A. Worth Hobby, Atlanta (1962)
 Virgil B. Williams, Griffin (1964)
 Thomas W. Goodwin, Augusta, *Ex-officio*
 Fred H. Simonton, Chickamauga, *Ex-officio*

ASSOCIATION BOARDS AND SUB-COMMITTEES

Board of Medical Education

J. W. Chambers, LaGrange, *Chairman* (1964)
 T. A. Sappington, Thomaston, *Vice-Chairman* (1964)
 George Dillinger, Thomasville (1963)
 Walter Bloom, Marietta (1962)
 W. D. Jarrat, Macon (1962)
 W. H. M. Weaver, Macon (1963)
 Ben K. Looper, Canton (1962)

Sub-Committee on Medical School Course

T. A. Sappington, Thomaston, *Chairman*
 F. N. Harrison, Augusta
 Alton V. Hallum, Atlanta

Sub-Committee on Medical Education

Walter Bloom, Marietta, *Chairman*
 James C. Metts, Savannah
 J. Willis Hurst, Atlanta
 Harry B. O'Rear, Augusta, *Ex-officio*
 A. P. Richardson, Atlanta, *Ex-officio*

Sub-Committee on AMEF

W. D. Jarrat, Macon, *Chairman*
 Corbett H. Thigpen, Augusta
 C. B. Elliott, Cedartown
 Edgar Boling, Atlanta
 Mrs. Bruce Threatte, Columbus
 Ralph W. Fowler, Marietta

Sub-Committee on Clarkesville Labs

Ben K. Looper, Canton, *Chairman*
 Sam Talmadge, Athens
 Hamil Murray, Gainesville
 Lee Howard, Jr., Savannah

Board of Hospital Activities

Ralph N. Johnson, Rome, *Chairman* (1964)
 Walter E. Brown, Savannah, *Vice-Chairman* (1964)
 Rafe Banks, Gainesville (1963)
 Jack C. Norris, Atlanta (1962)

Sub-Committee on Blood Banks

Jack C. Norris, Atlanta, *Chairman*
 Irving Greenberg, Atlanta
 Walter Sheppard, Augusta

Sub-Committee on Hospital Relations

Rafe Banks, Gainesville, *Chairman*
 W. L. Pomeroy, Waycross
 Milford B. Hatcher, Macon
 C. W. Mills, Jr., Atlanta
 P. W. Warga, Athens

Board of Governmental Medical Services

Luther H. Wolff, Columbus, *Chairman* (1964)
 W. Bruce Schaefer, Toccoa, *Vice-Chairman* (1964)
 A. W. Simpson, Washington (1963)
 Eugene Griffin, Atlanta (1962)
 Edgar M. Dunstan, Atlanta (1962)
 Robert L. Bennett, Warm Springs (1962)
 R. W. Edenfield, Macon (1963)
 Ernest B. Dunlap, Atlanta (1962)
 John Bowen, Sandy Springs (1963)

Sub-Committee on Maternal and Infant Welfare

Eugene Griffin, Atlanta, *Chairman*
 Helen W. Bellhouse, Atlanta, *Vice-Chairman*
 H. J. Bickerstaff, Columbus
 James W. Bennett, Augusta
 Peter Hydrick, College Park
 J. W. Smith, Manchester
 A. G. Leroy, Thomson
 C. I. Bryans, Augusta
 Luella M. Klein, Atlanta
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65—THOMAS-BROOKS—1962

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Julian B. Neel, Thomasville, Secretary

66—TIFT—1961

H. E. Aderholt, Tifton, President
Paul W. Lucas, Tifton, Secretary

68—TROUP—1962

C. W. Harvey, Hogansville, President
J. T. Mitchell, LaGrange, Secretary

69—UPSON—1961

J. M. Kellum, Thomaston, President
J. M. Woodall, Thomaston, Secretary

70—WALKER-CATOOSA-DADE—1962

Robert T. Jones, Lafayette, President
John C. Ellis, Rossville, Secretary

71—WALTON—1962

C. C. Moreland, Logansville, President
Stevens Byars, Monroe, Secretary

72—WARE—1962

M. T. McGoogan, Waycross, President
S. W. Clark, Jr., Waycross, Secretary

73—WARREN—1961

H. B. Cason, Warrenton, President
A. W. Davis, Warrenton, Secretary

74—WASHINGTON—1962

Thomas W. Gilmore, Sandersville, President

75—WAYNE—1962

James Woodrow Yeomans, Jesup, President
Daniel H. G. Glover, Jesup, Secretary

76—WHITFIELD—1962

Herschel U. Martin, Dalton, President
David A. Wells, Dalton, Secretary

78—WILKES—1961

H. W. Harper, Washington, President
Harry Cheves, Union Point, Secretary

79—WORTH—1961

H. G. Davis, Jr., Sylvester, Secretary

Woman's Auxiliary to the Medical Association of Georgia

37th Annual Meeting

May 6-9, 1962 — Savannah

President's Invitation

With this official invitation comes a warm personal one to each member of the Woman's Auxiliary to the Medical Association of Georgia to attend its 37th Annual Convention at the DeSoto Hotel, Savannah, Georgia, May 6-9, 1962.

The pleasure of sharing experiences in community service and other fields, cooperative planning for further achievements, and Savannah's charm and famed hospitality await you.

Mrs. A. Worth Hobby

President, Woman's Auxiliary of the
Medical Association of Georgia



Mrs. A. Worth Hobby



Mrs. Dan H. Willoughby

Welcome to Savannah

The Auxiliary to the Georgia Medical Society, the first medical society in our state, welcomes you to Savannah, a historic city founded on the Savannah River Bluff in 1733.

We hope to entertain you with true southern hospitality, showing you some of the old, much of the new, all intended for the greatest enjoyment of your stay in our community.

Mrs. Dan H. Willoughby

President, Woman's Auxiliary of the
Georgia (Chatham) Medical Society

ORGANIZATION

of the

Woman's Auxiliary to the Medical Association of Georgia

Officers, 1961-1962

President—Mrs. A. Worth Hobby.....Atlanta
 President-Elect—Mrs. Ennis W. Waldemayer.....Americus
 First Vice-President—Mrs. F. N. Harrison.....Augusta
 Second Vice-President—Mrs. William K. Jordan.....Macon
 Third Vice-President—Mrs. J. M. Skinner.....Griffin
 Corresponding Secretary—Mrs. Henry E. Steadman.....Hapeville
 Recording Secretary—Mrs. Louie H. Griffin.....Claxton
 Treasurer—Mrs. George M. Hutto.....Columbus
 Historian—Mrs. L. G. Cacchioli.....Hartwell
 Parliamentarian—Mrs. Shelley C. Davis.....Atlanta

Advisory Committee

Dr. Luther H. Wolff, *Chairman*
 Dr. Fred H. Simonton, *Ex-officio*
 Dr. Thomas W. Goodwin, *Ex-officio*
 Dr. Remer Y. Clark.....Dr. A. Worth Hobby
 Dr. W. G. Elliott.....Dr. Virgil B. Williams

Standing Committee Chairmen

Achievement Award—Mrs. Edgar M. Dunstan.....Decatur
 American Medical Education Foundation—
 Mrs. Bruce Threatte.....Columbus
 Archives—Mrs. Edward L. Askren, Jr.....Atlanta
 Brawner Trophy—Mrs. W. P. Rhyne.....Albany
 Budget and Finance—Mrs. John A. Meier.....Albany
 Bulletin—Mrs. T. A. Peterson.....Savannah
 Bylaws and Procedure—Mrs. C. James Roper.....Jasper
 Civil Defense—Mrs. F. Kells Boland, Jr.....Atlanta
 Community Service—Mrs. William K. Jordan.....Macon
 Doctor's Day—Mrs. Floyd R. Sanders.....Decatur
 Editorial—Mrs. Robert T. Klingbeil.....Marietta
 Health Careers—Mrs. W. A. Mendenhall.....Chamblee
 Legislation—Mrs. J. M. Skinner.....Griffin
 Membership—Mrs. Ennis W. Waldemayer.....Americus
 Mental Health—Mrs. Rives Chalmers.....Atlanta
 Program—Mrs. F. N. Harrison.....Augusta
 Research in Romance of Medicine—Mrs. Hayward S. Phillips.....Augusta
 Rural Health—Mrs. S. W. Clark, Jr.....Waycross
 Safety—Mrs. Oscar H. Lott.....Savannah
 Scrapbook—Mrs. Douglas L. Head, Jr.....Thomasston
 State Handbook—Mrs. Luther H. Wolff.....Columbus
 Student Loan Fund—Mrs. Charles I. Bryans.....Augusta

Special Committee Chairmen

Crawford W. Long Note Paper—Mrs. E. V. Patrick.....Carrollton
 Auxiliary Headquarters Room—Mrs. Remer Y. Clark.....Marietta
 Mrs. Ted F. Leigh, *Co-Chairman*.....Atlanta

District Councilors

First—Mrs. John L. Alexander.....Savannah
 Second—Mrs. Eschol E. Davis.....Thomasville
 Third—Mrs. Martin Malloy.....Vienna
 Fourth—Mrs. James M. Skinner.....Griffin
 Fifth—Mrs. John T. Leslie.....Avondale Estates
 Sixth—Mrs. Curtis F. Veal.....Milledgeville
 Seventh—Mrs. Roy Rabb.....Calhoun
 Eighth—Mrs. A. R. Pumpelly.....Jesup
 Ninth—Mrs. Charles R. Andrews.....Canton
 Tenth—Mrs. John F. Barner.....Athens

Councilor, Woman's Auxiliary to the Southern Medical Association

Mrs. Luther H. Wolff, Columbus

County Auxiliary Presidents

Baldwin (Putnam)—Mrs. Joseph G. Bohorofoush.....Milledgeville
 Bibb (Crawford, Jones, Monroe, Twigg, Wilkinson)—
 Mrs. Thomas H. Williams.....Macon
 Bulloch-Candler-Evans—Mrs. R. L. Pence.....Metter
 Carroll-Douglas-Haralson—Mrs. R. D. Allen.....Tallapoosa
 Chatham—Georgia Medical Society (Bryan, Long, Liberty,
 Effingham, McIntosh)—Mrs. D. H. Willoughby.....Savannah
 Chattahoochee (Gwinnett, Forsyth)—Mrs. Rupert Bramblett.....Cumming
 Chattooga—Mrs. W. P. Martin.....Summerville
 Cherokee-Pickens—Mrs. C. James Roper.....Jasper
 Cobb—Mrs. James H. Manning.....Marietta
 Coffee—Mrs. Calvin S. Meeks.....Douglas
 Colquitt—Mrs. John F. McCoy.....Moultrie
 Crawford W. Long—Mrs. John Barner.....Athens

DeKalb—Mrs. Glenn A. Duncan.....Decatur
 Dougherty—Mrs. T. Gray Fountain.....Albany
 Elbert-Franklin-Hart—Mrs. J. Hubert Milford.....Hartwell
 Flint (Crisp, Turner, Dooley)—Mrs. Woodrow Goss.....Ashburn
 Floyd—Mrs. Coleman T. King.....Rome
 Fulton—Mrs. J. Luther Clements, Jr.....Atlanta
 Glynn—Mrs. Bert H. Malone.....Brunswick
 Gordon—Mrs. Wilbut D. Hall.....Calhoun
 Habersham (Towns, White)—Mrs. Charles M. Henry.....Clarksville
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 Mitchell—Mrs. M. W. Williams.....Camilla
 Muscogee—Mrs. Leon Lapides.....Columbus
 Ocmulgee (Bleckley, Dodge, Pulaski, Wilcox)—
 Mrs. Richard L. Smith.....Cochran
 Richmond (Columbia)—Mrs. Theodore Everett.....Augusta
 South Georgia (Lowndes, Lanier, Berrien, Cook, Clinch)—
 Mrs. Owen K. Youles, Jr.....Valdosta
 Southwest Georgia (Calhoun, Early, Miller, Baker, Clay)—
 Mrs. Homer Wood.....Fort Gaines
 Spalding (Butts, Lamar, Henry, Pike)—
 Mrs. John Weldon Kelley.....Griffin
 Stephens—Mrs. Irving Hellenga.....Toccoa
 Sumter-Schley-Macon-Marion—Mrs. Carl P. Savage, Jr.....Montezuma
 Thomas-Brooks—Mrs. M. G. Middleton.....Thomasville
 Tift—Mrs. Tom Edmondson.....Tifton
 Troup-Heard—Mrs. C. Mark Whitehead.....LaGrange
 Upson—Mrs. Herbert D. Tyler.....Thomasston
 Walker-Catoosa-Dade—Mrs. H. Norton Hutchinson.....Trenton
 Ware (Bacon, Brantley, Camden, Charlton, Jeff Davis, Pierce)—
 Mrs. Duncan Farris.....Waycross
 Washington—Mrs. Marion W. Hurt.....Sandersville
 Wayne—Mrs. C. L. Meadows.....Jesup
 Whitfield-Murray—Mrs. Paul Bradley.....Dalton
 Worth—Mrs. H. G. Davis.....Sylvester

Past Presidents and Conventions

Honorary Presidents for Life

Mrs. James N. Brawner, Sr., Atlanta
 Mrs. Eustace A. Allen, Atlanta

1924—Augusta (Organization)—Mrs. C. W. Roberts, Atlanta
 (Deceased), Temporary Chairman
 1925—Atlanta—Mrs. James N. Brawner, Sr., Atlanta
 1926—Albany—Mrs. William H. Myers, Savannah
 1927—Athens—Mrs. C. W. Roberts, Atlanta (Deceased)
 1928—Savannah—Mrs. Paul Holiday (Mrs. J. C. Moore, Gaffney, S. C.)
 1929—Macon—Mrs. Charles C. Hinton, Macon
 1930—Augusta—Mrs. Marion T. Benson, Atlanta (Deceased)
 1931—Macon—Mrs. Charles C. Harrold, Macon (Deceased)
 1932—Savannah—Mrs. Ralston Lattimore, Savannah
 1933—Macon—Mrs. S. T. R. Revell, Louisville
 1934—Augusta—Mrs. J. Bonar White, Atlanta (Deceased)
 1935—Atlanta—Mrs. J. E. Penland, Waycross
 1936—Savannah—Mrs. Ernest R. Harris, Winder (Deceased)
 1937—Macon—Mrs. W. R. Dancy, Savannah
 1938—Augusta—Mrs. Ralph H. Chaney, Augusta
 1939—Atlanta—Mrs. Warren A. Coleman, Eastman
 1940—Savannah—Mrs. Eustace A. Allen, Atlanta
 1941—Macon—Mrs. H. G. Bannister, Ila
 1942—Augusta—Mrs. Lee Howard, Savannah
 1943—Atlanta—Mrs. J. Lon King, Macon
 1944—Savannah—Mrs. Olin S. Cofer, Atlanta
 1945—No Convention
 1946—Macon—Mrs. W. T. Randolph, Winder
 1947—Augusta—Mrs. W. Bruce Schaefer, Toccoa
 1948—Atlanta—Mrs. W. G. Elliott, Cuthbert
 1949—Savannah—Mrs. S. A. Anderson, Atlanta
 1950—Macon—Mrs. J. Harry Rogers, Atlanta
 1951—Augusta—Mrs. Lehman W. Williams, Savannah
 1952—Atlanta—Mrs. J. R. S. Mays, Macon
 1953—Savannah—Mrs. Ralph W. Fowler, Marietta
 1954—Macon—Mrs. Leo Smith, Waycross
 1955—Augusta—Mrs. Shelley C. Davis, Atlanta
 1956—Atlanta—Mrs. Robert C. Major, Augusta
 1957—Savannah—Mrs. Walker L. Curtis, College Park
 1958—Macon—Mrs. John L. Elliott, Savannah
 1959—Augusta—Mrs. Luther H. Wolff, Columbus
 1960—Columbus—Mrs. Remer Y. Clark, Marietta
 1961—Atlanta—Mrs. W. P. Rhyne, Albany

Convention Committees

WOMAN'S AUXILIARY TO THE GEORGIA (CHATHAM COUNTY) MEDICAL SOCIETY

General Chairmen

Mrs. T. A. Peterson, *Chairman*
 Mrs. John B. Rabun, *Co-Chairman*

Arrangements

Mrs. Dan Willoughby, *Chairman*
Mrs. John Elliott, *Co-Chairman*

Credentials and Registration

Mrs. D. B. Fillingim, *Chairman*
Mrs. Herman Delancy, *Co-Chairman*
Mrs. L. J. Rabhan, Mrs. Harvey Morgan, Mrs. R. L. Stone, Mrs. J. P. Evans, Mrs. Robert Innes, Mrs. H. H. McGee, Jr., Mrs. Louis Leopold, Mrs. H. Y. Righton, Mrs. Mason Robertson, Mrs. Julian Quattlebaum, Jr., Mrs. Jeff Holloman, Mrs. H. E. Puckett, Mrs. Edwin Shepherd, Mrs. Charles Usher, Jr.

Executive Board Meetings

Mrs. A. H. Center, *Pre-Convention Luncheon*
Mrs. S. F. Rosen, *Post-Convention Breakfast*

Flowers and Decorations

Mrs. O. H. Lott, *Chairman*
Mrs. W. D. Wilson, *Co-Chairman*
Mrs. L. M. Freedman, Mrs. R. B. Gottschalk
Mrs. David Robinson, *Chairman (Monday night)*
Mrs. E. F. Rosen, *Co-Chairman*
Mrs. Fenwick Nichols, Mrs. Allen Coward, Mrs. J. C. Metts, Jr., Mrs. Meyer Schneider, Mrs. J. H. Pinholster, Mrs. Lester Neville, Mrs. J. K. Quattlebaum, Sr.

Hospitality

Mrs. Joseph Pacifici, *Chairman*
Mrs. Fred Kessler, *Co-Chairman*
Mrs. John Withington, Mrs. E. N. Gleaton, Mrs. H. H. McGee, Sr., Mrs. R. L. Schley, Mrs. Carter Wright, Mrs. Farnum Coffin, Mrs. Charles Usher, Jr.

Luncheon and Fashion Show (Tuesday)

Mrs. Lloyd Osteen, *Chairman*
Mrs. Harry Portman, *Co-Chairman*
Mrs. John Stalvey, Mrs. Harry Duncan, Mrs. Bert Brown, Mrs. John Rabun

Recognition Luncheon (Monday)

Mrs. J. L. Alexander, *Chairman*
Mrs. Upton Clary, *Co-Chairman*
Mrs. Dearing Nash

Past Presidents' Luncheon (Monday)

Mrs. L. W. Williams, *Chairman*

Boat Ride

Mrs. Harold Smith, *Chairman*
Mrs. Jules Victor, *Co-Chairman*
Mrs. John Daniel, Mrs. Henry Frech, Mrs. L. R. Lanier, Mrs. W. W. Buckhaults, Mrs. J. J. Doolan, Mrs. Vincent Cirincione

Pages

Mrs. John Sharpley, *Chairman*
Mrs. Frank Hardeman, *Co-Chairman*
Mrs. J. A. Heffernan, Mrs. Ray Webb, Mrs. Andro Phillips, Mrs. W. W. Osborne, Mrs. Lamont Danzig, Mrs. Frank Hoffman, Mrs. Charles Sax, Mrs. Irving Victor

Publicity

Mrs. John Howard, *Chairman*
Mrs. Grant Goldenstar, *Co-Chairman*
Mrs. Vincent Cirincione, Mrs. Franklyn Bousquet

Presidents' Banquet

Mrs. John Porter, *Chairman*
Mrs. Walter Brown, *Co-Chairman*
Mrs. Kirk Train, Mrs. Charles Prince, Mrs. W. H. Lippitt, Mrs. Peter Scardino, Mrs. Walter Bedingfield, Mrs. Bert Brown, Mrs. Lawrence Bodziner, Mrs. Ernest Edwards, Mrs. Lawrence Lee, Mrs. T. A. McGoldrick, Mrs. Howard Morrison, Mrs. Ruskin King

Memorial

Mrs. John Rabun, *Chairman*
Mrs. D. L. Brawner, Mrs. H. E. Puckett, Mrs. Henry Brandt, Mrs. Harry Rollings

Transportation

Mrs. Mel Berlin, *Chairman*
Mrs. T. A. Amburgey, *Co-Chairman*
Mrs. Robert Drane, Mrs. John Zirkle, Mrs. Joseph McCormick, Mrs. J. C. Metts, Sr., Mrs. Carroll Beasley, Mrs. Carl Brennan

Teller and Timekeepers

Mrs. Lee Howard, Sr., *Chairman*
Mrs. W. R. Dancy, *Co-Chairman*

Resolutions Chairman

Mrs. Glenn A. Duncan, Decatur

Hospitality Chairman

(*Personal Representative of the President*)
Mrs. Walker L. Curtis, College Park

Courtesy Chairman

Mrs. James N. Brawner, Atlanta

Reading Committee

Mrs. Floyd R. Sanders, Decatur
Mrs. S. W. Clark, Waycross
Mrs. C. James Roper, Jasper

Pledge of Loyalty to the

Woman's Auxiliary
Medical Association of Georgia

"I pledge my loyalty and devotion to the Woman's Auxiliary to the Medical Association of Georgia. I will support its activities, protect its reputation, and ever sustain its high ideals."

Collect

"Keep us, O God, from pettiness; let us be large in thought, word and deed. Let us be done with faultfinding, and leave off self-seeking. May we put away pretense, and meet each other face to face, without self-pity and without prejudice.

May we never be hasty in judgment, and always generous. Let us take time for all things; make us to grow calm, serene, gentle.

Teach us to put into action our better impulses, straightforward and unafraid. Grant that we may realize it is the little things that create differences; but in the big things of life we are one.

And, may we strive to reach and to know the great, common woman's heart of us all, and O, Lord, let us not forget to be kind."

The Program

SUNDAY, MAY 6

11:00 Registration

to
5:00 Lobby—DeSoto Hotel

Hospitality

Rooms 100 — 102

1:00 Pre-Convention Executive Board Meeting—Dutch Luncheon

(For 1961-62 officers, state chairmen, district councilors, county presidents, county presidents-elect, past state presidents, and councilor to Southern Medical Association Auxiliary)

Gold Room, DeSoto Hotel

PRESIDING

Mrs. A. Worth Hobby, Atlanta, President

INVOCATION

Mrs. L. W. Williams, Savannah

PLEDGE OF LOYALTY AND COLLECT

Mrs. D. L. Head, Jr., Thomaston

5:00 Joint Meeting—MAG House of Delegates and Woman's Auxiliary

Main Ball Room, Hotel DeSoto

PRESIDING

J. Frank Walker, M.D., Atlanta,
Speaker of the House

ORDER OF BUSINESS (See MAG Delegate's Handbook)

REPORT OF PRESIDENT WOMAN'S AUXILIARY TO MEDICAL ASSOCIATION OF GEORGIA

Mrs. A. Worth Hobby, Atlanta

THE TRIANGLE OF MEDICINE—RESEARCH AND PATIENT CARE

Hugh H. Hussey, M.D., Washington, D. C.,
Chairman, Board of Trustees, American
Medical Association

MONDAY, MAY 7

8:30 Registration

to
3:30 Lobby — DeSoto Hotel

Hospitality

Gold Room Foyer, DeSoto Hotel

9:30 General Meeting

Gold Room, DeSoto Hotel

CALL TO ORDER

Mrs. A. Worth Hobby, Atlanta, President

INVOCATION

The Reverend David F. Cripps, Pastor,
Epworth Methodist Church, Savannah

PLEDGE OF LOYALTY AND COLLECT

Mrs. Remer Y. Clark, Marietta

ADDRESS OF WELCOME

Mrs. Dan Willoughby, Savannah, President,
Woman's Auxiliary to the Georgia
Medical Society (Chatham County)

RESPONSE TO WELCOME

Mrs. Bruce Threatte, Columbus

INTRODUCTION OF HONOR GUESTS AND PAST STATE PRESIDENTS

Mrs. Walker L. Curtis, College Park

PRESENTATION OF CONVENTION PLANS

Mrs. T. A. Peterson, Savannah,
General Chairman

INTRODUCTION OF PAGES FOR THE DAY

Mrs. Joseph Pacifici, Savannah,
Hospitality Chairman

REPORT OF ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA

Luther H. Wolff, M.D., Columbus, Chairman

GREETINGS

Fred H. Simonton, M.D., Chickamauga,
President, Medical Association
of Georgia

Thomas W. Goodman, M.D., Augusta,
President-Elect, Medical Association
of Georgia

INTRODUCTION OF GUEST SPEAKER

Mrs. Leo Smith, Waycross, Director,
Woman's Auxiliary to the American
Medical Association

ADDRESS

Mrs. Harlan English, Danville, Illinois,
President, Woman's Auxiliary to the
American Medical Association

Business Session

CONVENTION RULES OF ORDER

Mrs. Shelley C. Davis, Atlanta,
Parliamentarian

ROLL CALL

Mrs. Louie H. Griffin, Claxton, Secretary

REPORTS:

President

Mrs. A. Worth Hobby, Atlanta

President-Elect

Mrs. Ennis W. Waldemayer, Americus

Treasurer (Including Auditor's Report)

Mrs. George M. Hutto, Columbus

ADDENDUM REPORTS:

Complete Reports (As given in 1961-
1962 Annual Report Book)

Recommendations from the Executive
Board Revisions

Mrs. C. James Repor, Chairman

Report of Credentials Committee

Mrs. D. B. Fillingim

ANNOUNCEMENTS

MEMORIAL SERVICE

Mrs. John Rabun, Savannah

RECESS OF SESSION

12:30 Dutch Luncheon

(For past presidents of Woman's Auxiliary to the Medical Association of Georgia)

Georgian Room, DeSoto Hotel

PRESIDING

Mrs. W. P. Rhyne, Albany, Immediate
Past President

12:30 Recognition (Dutch) Luncheon

(For all registered members, honoring
district councilors, county presidents,
county presidents-elect)

PRESIDING

Mrs. Ennis Waldemayer, Americus,
President-Elect

Garden Room of The Pirates' House,
20 East Broad Street

(Transportation available, Bull Street entrance of hotel)

- 3:00 Cruising Down the (Savannah) River**
to Boat Ride — Entertainment — Snacks
4:30 (Transportation available, Bull Street entrance of hotel)

TUESDAY, MAY 8

- 9:00 Registration**
to
12:30 *Foyer, DeSoto Hotel*
- Hospitality**
Gold Room Foyer, DeSoto Hotel
- 9:30 Continued General Meeting**
Gold Room, DeSoto Hotel
- CALL TO ORDER
Mrs. A. Worth Hobby, Atlanta, President
- INVOCATION
Dr. Frank E. Morris, Pastor, Bull Street Baptist Church, Savannah
- PLEDGE OF LOYALTY AND COLLECT
Mrs. S. W. Clark, Waycross
- INTRODUCTION OF PAGES FOR THE DAY
Mrs. Joseph Pacifici, Savannah, Hospitality Chairman
- ANNOUNCEMENTS OF CONVENTION PLANS
Mrs. John Rabun, Savannah, Convention Co-Chairman
- ANNOUNCEMENTS
RESUME OF GEORGIA'S CONTRIBUTION TO THE SOUTHERN MEDICAL ASSOCIATION
Mrs. Luther H. Wolff, Columbus, Councilor to the Southern Medical Association
Mrs. Louie H. Griffin, Claxton, Second Vice President

- 1:00 Luncheon and Fashion Show**
(For all Auxiliary Convention Members)
(Fashion Show by Laurette's)

*First Federal Penthouse,
132 East Broughton Street*

PRESIDING

Mrs. A. Worth Hobby, Atlanta,
Retiring President

INTRODUCTION OF GUEST SPEAKER

Mrs. Farnum Coffin, Savannah

ADDRESS

Mr. Alexander A. Lawrence, Savannah

Business Session

ROLL CALL AND MINUTES

Mrs. Louie H. Griffin, Claxton, Secretary

REPORT OF REVISIONS COMMITTEE

Mrs. C. James Roper, Jasper, Chairman

REPORT OF BUDGET AND FINANCE COMMITTEE

Mrs. John A. Meier, Albany

- REPORT OF RESOLUTIONS COMMITTEE
Mrs. Glenn A. Duncan, Decatur
- REPORT OF CREDENTIALS COMMITTEE
Mrs. David Fillingim, Savannah
- REPORT OF COURTESY COMMITTEE
Mrs. J. N. Brawner, Atlanta
- REPORT OF AWARD COMMITTEES:
- Achievement
Mrs. E. M. Dunstan, Atlanta, Chairman
- Civil Defense
Mrs. F. Kells Boland, Jr., Atlanta, Chairman
- Doctor's Day
Mrs. Floyd R. Sanders, Decatur, Chairman
- Mrs. J. Bonar White Scrapbook
Mrs. D. L. Head, Jr., Thomaston, Chairman
- Safety
Mrs. Oscar H. Lott, Savannah, Chairman
- Brawner Trophy for General Excellence
Mrs. W. P. Rhyne, Albany, Chairman
- REPORT OF NOMINATING COMMITTEE
Mrs. Thomas H. Williams, Macon, Chairman
- ELECTION OF OFFICERS
- INSTALLATION OF OFFICERS
Mrs. Shelley C. Davis, Atlanta

WEDNESDAY, MAY 9

- 9:00 Post-Convention Board Meeting—Dutch Breakfast**

(For 1962-63 officers, chairmen, district councilors, county presidents, county presidents-elect, past presidents, and councilor to SMA)

Gold Room, DeSoto Hotel

PRESIDING:

Mrs. Ennis W. Waldemayer, President

- 11:00 MAG General Business Session**

(ALL MAG AND AUXILIARY MEMBERS
AND GUESTS INVITED)

PRESIDING

Fred H. Simonton, Chickamauga, President

PRESENTATION OF 50 YEAR CERTIFICATES

Milford B. Hatcher, Macon, Immediate Past President, Medical Association of Georgia

PRESENTATION OF SCIENTIFIC EXHIBIT AWARDS

Edgar Grady, Atlanta, Chairman,
Scientific Awards Committee

PRESENTATION OF GENERAL PRACTITIONER OF THE YEAR AWARD

Charles E. McArthur, Cordele, President,
Georgia Academy of General Practice

PRESENTATION OF MAG CERTIFICATES OF APPRECIATION

John T. Mauldin, Atlanta, Secretary,
Medical Association of Georgia

PRESENTATION OF HARDMAN AWARD

Thomas W. Goodwin, Augusta, President-Elect, Medical Association of Georgia

PRESENTATION OF MAG DISTINGUISHED SERVICE AWARD

Fred H. Simonton, Chickamauga, President, Medical Association of Georgia

SELECTION OF SITE FOR ANNUAL MEETING 1964

ANNOUNCEMENT OF MAG ELECTION RESULTS

Chairman, Tellers Committee

INSTALLATION OF 1962-1963 OFFICERS

Fred H. Simonton, Chickamauga, Immediate Past President, Medical Association of Georgia

ADJOURNMENT OF 108TH ANNUAL SESSION

NOTE: Tickets are available at registration desk for Auxiliary Convention Members for the boat ride and luncheon on Monday and the luncheon-fashion show on Tuesday. Please register at registration desk for transportation.

Rules to Govern the Convention

1. The voting body of the convention shall consist of the members of the Executive Board of the Woman's Auxiliary to the Medical Association of Georgia and the duly accredited delegates from the county auxiliaries. No one is entitled to vote until registered.
 2. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.
 3. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.
 4. Badges must be worn by members of the voting body during all general sessions of the convention.
 5. Delegates' privileges are not transferable.
 6. All motions shall be presented in writing to the Recording Secretary. They shall be signed by the persons making and seconding the motion.
 7. All original motions on resolutions shall be made by submitting two copies, one to the Resolution Committee and one to the Recording Secretary.
 8. All persons appearing on the program must be seated near the platform when the session opens.
- Whispering greatly retards the business of the meeting. Order must be maintained at all times. Please be prompt. Meetings will begin promptly at the time announced.

**blood pressure approaches normal
more readily, more safely....simply**

**with
Salutensin[®]**

(hydroflumethiazide, reserpine, protoveratrine A—antihypertensive formulation)

Early, efficient reduction of blood pressure. Only Salutensin combines the advantages of protoveratrine A ("the most physiologic, hemodynamic reversal of hypertension"¹) with the basic benefits of thiazide-rauwolfia therapy. The potentiating/additive effects of these agents²⁻⁸ provide increased antihypertensive control at dosage levels which reduce the incidence and severity of unwanted effects.

Salutensin combines Saluron[®] (hydroflumethiazide), a more effective 'dry weight' diuretic which produces up to 60% greater excretion of sodium than does chlorothiazide⁹; reserpine, to block excessive pressor responses and relieve anxiety; and protoveratrine A, which relieves arteriolar constriction and reduces peripheral resistance through its action on the blood pressure reflex receptors in the carotid sinus.

Added advantages for long-term or difficult patients. Salutensin will reduce blood pressure (both systolic and diastolic) to normal or near-normal levels, and maintain it there, in the great majority of cases. Patients on thiazide-rauwolfia therapy often experience further improvement when transferred to Salutensin. Further, therapy with Salutensin is both economical and convenient.

Each Salutensin tablet contains: 50 mg. Saluron[®] (hydroflumethiazide), 0.125 mg. reserpine, and 0.2 mg. protoveratrine A. See Official Package Circular for complete information on dosage, side effects and precautions.

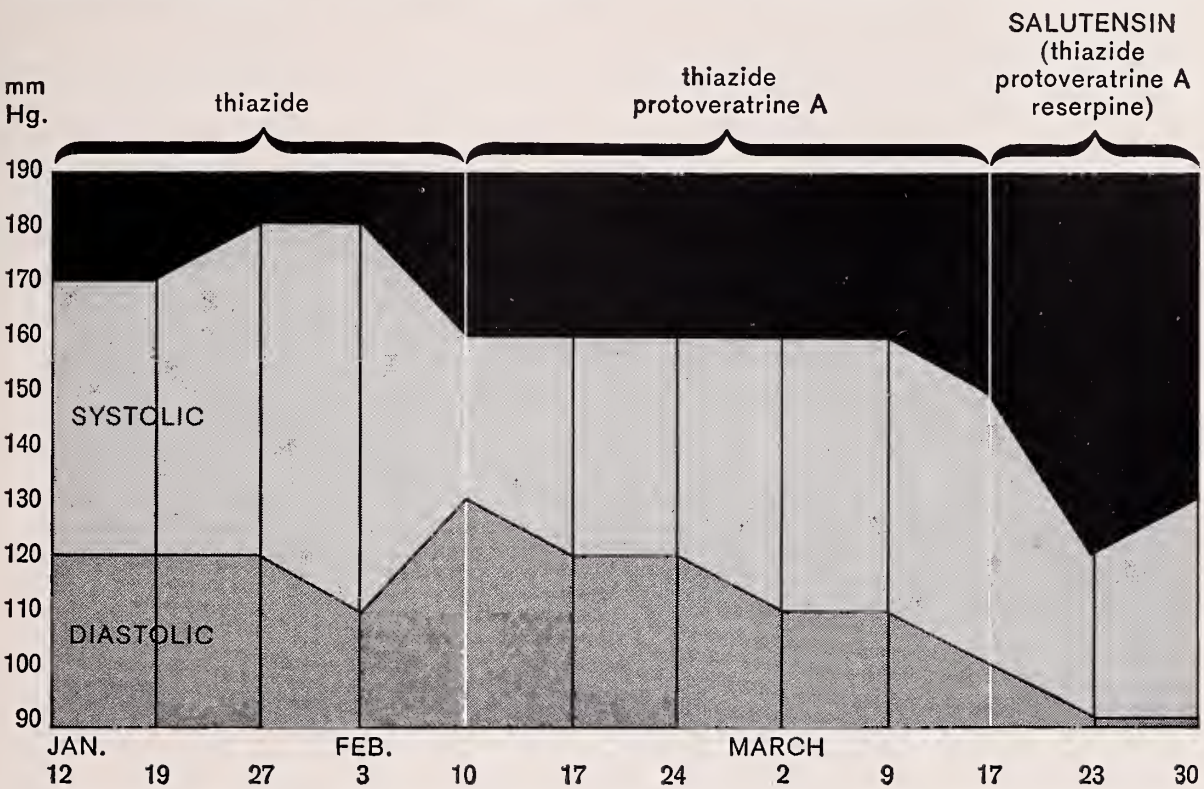
Supplied: Bottles of 60 scored tablets.

References: 1. Fries, E. D.: In Hypertension, ed. by J. H. Moyer, Saunders, Phila., 1959 p. 123. 2. Fries, E. D.: South M. J. **51**:1281 (Oct.) 1958. 3. Finnerty, F. A. and Buchholz, J. H.: GP **17**:95 (Feb.) 1958. 4. Gill, R. J., et al.: Am. Pract. & Digest Treat. **11**:1007 (Dec.) 1960. 5. Brest, A. N. and Moyer, J. H.: J. South Carolina M. A. **56**:171 (May) 1960. 6. Wilkins R. W.: Postgrad. Med. **26**:59 (July) 1959. 7. Gifford, R. W., Jr.: Read at the Hahnemann Symp. on Hypertension, Phila. Dec. 8 to 13, 1958. 8. Fries, E. D., et al.: J. A. M. A. **166**:137 (Jan. 11) 1958. 9. Ford, R. V. and Nickell, J.: Ant. Med. & Clin. Ther. **6**:461, 1959.

**all the antihypertensive benefits of thiazide-rauwolfia therapy plus the specific,
physiologic vasodilation of protoveratrine A**

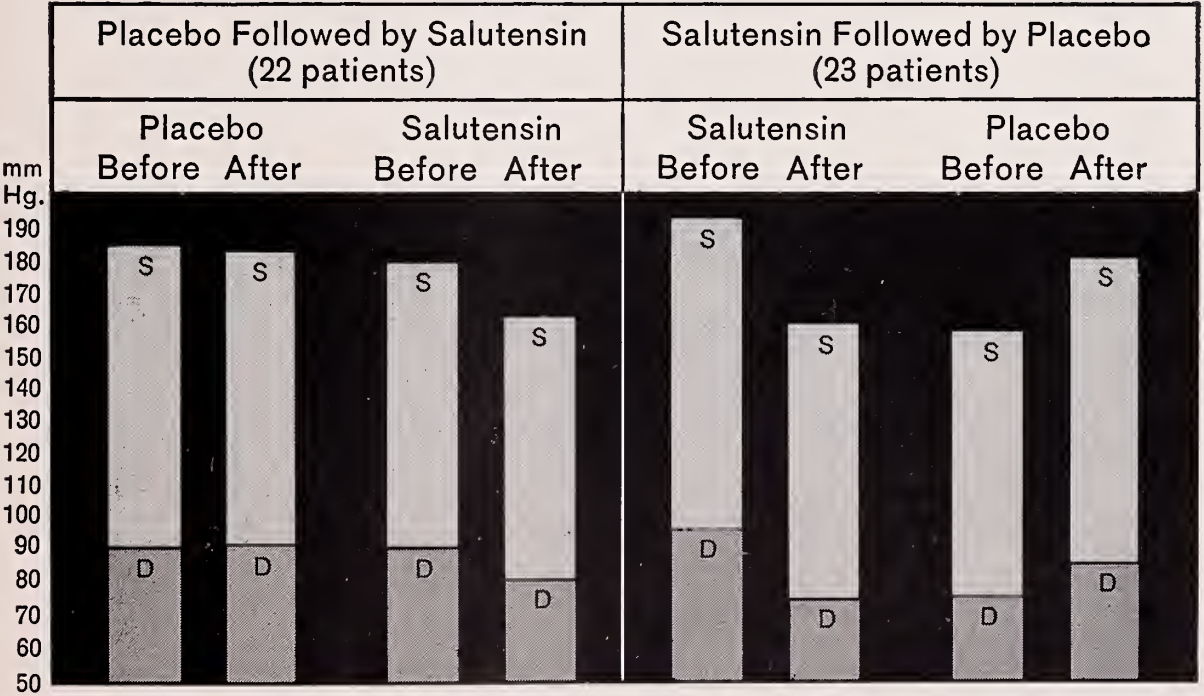
11 WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS BY SERIAL ADDITION OF THE INGREDIENTS IN SALUTENSIN IN A TEST CASE

(Adapted from Spiotta, E. J.: Report to Department of Clinical Investigation, Bristol Laboratories)



3½ WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS USING SALUTENSIN FROM THE START OF THERAPY IN A "DOUBLE BLIND" CROSSOVER STUDY

Mean Blood Pressures—Systolic (S) and Diastolic (D)



In this "double blind" crossover study of 45 patients, the mean systolic and diastolic blood pressures were essentially unchanged or rose during placebo administration, and decreased markedly during the 25 days of Salutensin therapy. (Smith, C. W.: Report to Department of Clinical Investigation, Bristol Laboratories.)



1962 CALENDAR OF MEETINGS

State

- Mar. 20-22—Pre and Postoperative Care, Medical College of Georgia, Augusta, 18 hrs. Cat. I.
- Mar. 22-24—Georgia Society of Ophthalmology and Otolaryngology, annual meeting, General Oglethorpe Hotel, Wilmington Island, Savannah.
- April 2-4—Augusta Postgraduate Medical Assembly (Coincides with practice rounds of the Masters Golf Tournament) Augusta.**
- May 6-9—Annual Session, Medical Association of Georgia.**
- June 4-9—Postgraduate course in Six Days of Cardiology, Emory University School of Medicine, Atlanta.

Regional

- Mar. 16-17—Southeastern Chapter of the Society of Nuclear Medicine, annual meeting, Academy of Medicine, Atlanta, Georgia.
- Mar. 18-21—Missouri State Medical Association, St. Louis.
- Mar. 26-28—American College of Surgeons, Sectional Meeting, Hotel Peabody, Memphis, Tenn.
- April 2-6—The Gill Memorial Eye, Ear and Throat Hospital, Annual Spring Congress in Ophthalmology and Otolaryngology and Allied Specialties, Roanoke, Virginia.
- April 8-11—Tennessee State Medical Association, Peabody Hotel, Memphis, Tenn.
- April 19-21—Postgraduate Symposium in Clinical and Practical Allergy, Mound Park Hospital Foundation, Inc., St. Petersburg, Florida.
- April 23-25—Annual Meeting West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, West Virginia.
- April 26-28—Alabama, Medical Association of the State of, Tutwiler Hotel, Birmingham, Ala.
- April 29-May 2—Arkansas Medical Society, Arlington Hotel, Hot Springs, Ark.
- May 5-9—Medical Society of North Carolina 108th Annual Meeting, Sir Walter Hotel, Raleigh.
- May 7-9—Louisiana State Medical Society, Hotel Frances, Monroe, La.
- May 8-10—Mississippi State Medical Association, Hotel Heidelberg, Jackson, Miss.
- May 8-10—South Carolina Medical Association, Ocean Forest Hotel, Myrtle Beach, S. C.
- May 9-13—Florida Medical Association, Americana Hotel, Miami Beach, Bal Harbour.
- May 12-15—Texas Medical Association, Austin, Tex.

National

- Mar. 20-23—American Association of Anatomists, Minneapolis, Minn.
- March 21-24—Neurosurgical Society of America, Buena Vista Hotel, Biloxi, Mississippi.
- March 30-April 1—American Society for the Study of Sterility, The Drake Hotel, Chicago.
- March—American Otorhinologic Society for Plastic Surgery, Philadelphia.
- April 1-6—American College of Allergists Graduate Instructional Course and 18th Annual Congress, Hotel Radisson, Minneapolis.
- April 2-14—Postgraduate course in Laryngology and Bronchoesophagology, University of Illinois College of Medicine, Chicago.
- April 2-5—American College of Obstetricians and Gynecologists, Palmer House, Chicago, Illinois.
- April 6-13—American Academy of General Practice, Las Vegas, Nev.
- April 9-12—Aerospace Medical Association, Atlantic City.
- April 9-13—American College of Physicians, Bellevue-Stratford Hotel, Philadelphia.
- April 16-18—American Association for Thoracic Surgery, Chase-Park Plaza Hotels, St. Louis.
- April 23-28—American Academy of Neurology, Statler-Hilton Hotel, New York City.
- April 30-May 2—American Academy of Pediatrics, spring meeting, Statler-Hilton, New York City.
- April 30-May 3—American Proctologic Society, Deauville Hotel, Miami Beach.
- April—American Association of Pathologists and Bacteriologists, Queen Elizabeth Hotel, Montreal, Canada.
- May 6-10—American Association of Plastic Surgeons, Hotel Del Coronado, Del Monte, Calif.
- May 28-30—American Ophthalmological Society, The Homestead, Hot Springs, Va.
- May 29-June 2—American College of Cardiology, Denver Hilton Hotel, Denver, Colo.
- June 4-22—Forty-seventh Session of the Trudeau School of Tuberculosis, Saranac Lake, New York.
- June 19-21—San Diego Symposium on Biomedical Engineering, Stardust Motel, San Diego, California.
- June 24-28—American Medical Association Annual Session, Chicago.**
- July 23-27—Postgraduate course in Cardiopulmonary Problems in Children, Edgewater Beach Hotel, Chicago.



FRED H. SIMONTON, M.D.

PRESIDENT'S LETTER

THE DOCTOR'S RESPONSIBILITY

WHAT IS A DOCTOR'S responsibility to society? Is it merely to practice the best medicine he knows how? Is his debt to society paid in full when he pursues his profession with all his energy to the exclusion of all else? Having done this, is his legacy to the future a settled matter? I think not and I believe that upon inspection and contemplation of the question you will agree.

Physicians, like lawyers, members of the clergy and indeed most any professional man has a responsibility and an obligation to society which goes beyond the practice of his profession. Perhaps to put this matter in truer perspective I should ask the question in the negative. That is, what would be the consequence of the total abdication of civic responsibility by professional people in this day and time? The answer is, I believe, self evident and altogether frightening.

The physician, whom I use here as being synonymous with all professional people, represents that great middle ground which has throughout the course of history been the fountainhead of progress and at the same time the wellspring of moderation. Where they have flourished and maintained for themselves the traditional freedoms of their profession, others have flourished and likewise have been able to retain their basic rights and freedoms. On the other hand, where the great middle ground has been eroded, either by the hand of tyranny or through abandonment of civic responsibility the opposite of freedom and self respect has come to rule.

To be specific in the case of medicine, however, it must be apparent to all who have followed medicine's legislative problems over the past decade

that even the scientific aspects of medicine are directly related to the social, economic and political climate in which the profession and the nation have labored. The medical profession, and indeed all professions enjoy a degree of freedom here unparalleled anywhere else in the world. This did not just happen. It is not the result of chance. Rather, it is due in part, at least, to the ready willingness of certain dedicated physicians to lay down their scalpels and take their turn at the wheel in order that a proper atmosphere could be maintained.

At times the odds have been great and they have never been greater than at present. For, with great pretense of virtue and in the name of progress, there exist in this country today power blocs determined to reverse the course of history back to an age when people were considered mere tools of the state. With assurances that the omnipotent state will provide everything for everybody, many a good man has been drugged into a false sense of security.

The medical profession, as perhaps the leading example of the great middle ground, has a debt not only to itself, but to all it holds dear. We are not engaged in a fight to merely determine how medical aid to the aged will be financed. This is simply one issue in a jungle of related problems. We are in the middle of a struggle to determine the future course of medicine and the future course of the nation itself.

We must hold up to the bright light of truth the false doctrines of our detractors and we must join hands with others who are making the same fight but on different battlegrounds. The fight we wage simply cannot be successful if done through the practice of our profession alone.

PRESIDENT'S LETTER / Continued

The only way we can raise the curtain on the world of paternalistic illusion is by greater participation in civic and political affairs. The old theory that medicine and politics do not mix is no longer valid. As responsible members of society we are bound by circumstance to devote a full measure of energy to the preservation of good and constructive government at all levels.

I urge each of you to take stock of your personal position. Medicine is not an island unto itself, but must become a working, fully related and thoroughly dedicated partner in the administration of society.

Fred H. Lumenton, MD

President, Medical Association of Georgia

MEDICAL ASSOCIATION OF GEORGIA

ANNUAL SESSION HEADQUARTERS

DeSoto Hotel

Savannah, Georgia

May 6-9, 1962





CONTACT LENSES

John L. Moore, Jr., *Atlanta*

THE SUPREME COURT OF OREGON on November 1, 1961, handed down an interesting decision affirming injunctions against an optician.

The findings of the facts set out in the Court's decision can be summarized as follows. The defendant optician had been advertising and holding himself out to the public as specializing in the fitting of contact lenses. Some of the professional eye doctors, both medical and optometric, exercised a much higher degree of control over the fitting of contact lenses than others. Some of the doctors sent in patients to the optician with a bare prescription as to visual correction. The prescription in some instances would contain a notation that the patient could try contact lenses. The doctors left it to the optician to measure the size and shape of the person's eye and decide the shape and curvature of the contact lenses. They also left to the optician the primary responsibility to fit the lens when it had been made. The optician testified that after he had made the initial fitting and testing, he always told the person to return to his doctor for a check. There was evidence in the case, however, to show that persons fitted with lenses would return repeatedly to the optician and not to the doctor for adjustment and testing.

Careful Supervision by Some Doctors

Other doctors would only order the lenses from the optician. When the lenses were completed, these doctors would require the optician to bring the lenses to the doctor's office and there fit the lenses and test them under the doctor's personal supervision. Sometimes the doctor would perform the full operation of fitting and testing himself. One optometrist testified that he considered the fitting of the lenses to be a part of his professional respon-

sibility. That optometrist testified that he exercised full control of the whole process.

The Supreme Court of Oregon stated that it was shocked to relate that much the highest percentage of prescriptions for contact lenses received by the optician left to him the major responsibility of making initial tests to determine the size as well as the actual fitting of the lenses.

Court's Decision

The Court found it clear that the fitting of contact lenses required some degree of professional skill and judgment. The Court considered it established that mechanical tests for size and shape were not conclusive in the fitting of contact lenses and that the peculiar nature of the lens and the shape of each individual's eye required professional judgment as well as mechanical exactness. Curvature of the eye, so essential to a proper fit, was not the same in any two persons, according to the evidence.

Terms of Injunction

The Supreme Court of Oregon upheld an injunction restraining the optician from doing any of the following, except when acting under the direct personal supervision of a legally qualified medical doctor or optometrist:

- (a) measuring portions of the cornea of any persons whatsoever and thereby determining the appropriate size and curvature of contact lenses suitable for use by the person;
- (b) giving advice to any person as to whether to wear contact lenses;
- (c) inserting, fitting, and adjusting contact lenses into the eyes of any person;
- (d) advertising by any means that he could perform any of the foregoing acts.

In Oregon apparently there is no statute regulating the practice of dispensing opticians. In Georgia, a 1956 Act, codified as Ga. Code Ann., Chapter 84-35, regulates the practice of dispensing opticians. "Dispensing optician" is defined to be one who prepares and dispenses lenses, spectacles, eye glasses, and optical devices to the intended users thereof on the written prescription of a physician or optometrist duly licensed to practice his profession. The dispensing optician is prohibited from engaging in the diagnosis of the diseases of the human eye or attempting to determine the refractive powers of the human eye. However, these definitions should be read in the light of the definition of "optometry"

in Code Section 84-1101. Optometrists are specifically allowed to prescribe contact lenses in an Act passed in 1956. Consequently, the right of opticians to "prepare" and "dispense" "lenses" should not be construed to include contact lenses.

It, therefore, seems fair to say that the principles of the Oregon case are equally valid in the State of Georgia. As a result physicians, ophthalmologists and optometrists should not participate in the practice of leaving to dispensing opticians the measurement of the cornea and the fitting of contact lenses except under the direct personal supervision of properly qualified professional personnel.¹

¹The case commented upon is *Oregon ex rel. The State Board of Examiners in Optometry v. Kuzirian*, 365 P. 2d 1046 (Sup. Ct. Ore. 1961).

Prepared at the request of the Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Sibley, Miller, Spann, and Shackelford, general counsel for the M.A.G.

MEDICAL SCHOOL COURSES OFFERED

Again in March-May, 1962, the Medical Association of Georgia will co-sponsor with the Medical College of Georgia, a lecture course for senior medical students known as "The Art of the Practice of Medicine." These informal lectures give insight into the "facts of life" about the non-scientific side of practice. The course is given at the Education Building, Medical College of Georgia on alternating Saturdays at 12:00 noon for 90 minute sessions.

The faculty for this series of lectures is chosen by the Association Medical School Course committee. Practitioners from private practice relate their actual experience to the subject matter selected for the lecture. The course was cooperatively designed by MAG Committee Chairman T. A. Sappington, Thomaston; Medical College of Georgia President Harry O'Rear and Dean W. G. Rice of Augusta and representatives of the Medical College senior class.

In conjunction with this course of study, Mead Johnson Laboratories furnishes data and materials on the subjects of the lectures. The Association, the Medical College and Mead Johnson Laboratories have collaborated on this project for the past five years.

Topics and faculty for the 1962 lecture course include:

"Types of Practice and Where to Practice"

Joseph Mercer, M.D., Brunswick and
Jule Neal, Jr., M.D., Macon

"Opening the Office and Licensure"

Rafe Banks, M.D., Gainesville

"Economics of an Office Practice"

J. Lee Walker, M.D., Nahunta

"Continuing Medical Education"

Walter Bloom, M.D., Atlanta

"Religion and Medicine"

Panel presentation by a Minister (Protestant),
Priest (Catholic) and a Rabbi (Jewish)

"M.D.'s Personal Economics"

Mr. Virlyn Moore, Jr., Atlanta.

While this course of study is not compulsory for the senior medical students at the Medical College of Georgia, past attendance at the sessions has included over 4/5ths of the senior class. Traditionally, student's wives are invited to attend the final lecture along with their husbands. A brief buffet social is held with the cooperation of Mead Johnson Laboratories, the Medical College faculty and the Association Medical School Course faculty and committee.



PSYCHIATRY'S GOLDEN AGE

By Winston E. Burdine, M.D., *Atlanta*

ALTHOUGH MENTAL ILLNESS has always been present among human populations in one form or another and in varying degree, it has recently risen in importance to become one of the major health problems of our time. This rise was certainly not due to the action of any single factor exclusively but rather is probably intermittently associated with the vast social changes characteristic of our era.

Mental illness is often precipitated by a crisis in the family, on the job, or elsewhere. Appropriate treatment given in an appropriate manner and at the appropriate time will often restore, equilibrium though not necessarily cure the patient of basic personality problems which make him prone to such crises.

Americans are becoming increasingly organized, industrialized, educated, and mobile both geographically and socially, while family ties have become less cohesive than formerly, and our roots in the community perhaps less firm. Man's increased control over his environment has resulted in an ever-higher standard of living and an ever-improving level of physical health, but at the same time, Americans have become more aware of the sizable amount of mental illness among us and of the emotional factors underlying or accompanying perhaps a significant proportion of our physical ills. Responsibility for care and treatment of the mentally ill is moving out from the mental hospital, into the community, the outpatient clinic, the general hospital, the physician's office and the home.

The public acceptance of the mentally ill as sick human beings in need of treatment rather than as creatures to be avoided and feared, results, to a great extent, from the development of drugs that provide effective medical treatment for some of the more distressing types of mental illness. Development of new anti-psychotic drugs represents a breakthrough in the field of mental disease and hopefully opens the way to further advances. Prior to this tremendous upsurge in the development of drugs, psychiatrists were making the best use of the

tools then available. So limited were the therapeutic measures that it is not surprising that the so-called treatment of the chronic psychotic patient was chiefly a matter of custodial care. In the popular expression, patients were not admitted to hospitals, they were "put away" and they were often "put away" for life. Few patients other than those whose psychotic episode was either self-limiting or responsive to shock therapy ever left the confines of the institution in which they had been "put away." Except for building more and more institutions there seemed to be no solution to the problem, but a dramatic change occurred in 1955 when drugs became available for widespread use. The very next year, 1956, for the first time in the history of mental health the number of patients discharged from mental hospitals exceeded the number of patients admitted to them. It was the beginning of the trend that still continues despite the fact that because of our rapidly expanding population, the actual number of patients admitted to mental hospitals has been steadily increasing.

The alleviation of human misery this change represents is virtually impossible to determine. Its considerable importance to our economy is not, however. When a patient rejoins society, he becomes a contributor to rather than a ward of his community; a taxpayer rather than a tax consumer.

Moreover the larger number of patients now being discharged from mental hospitals is only a small part of the story. The new drugs also prevent many people from relapsing and returning to the hospital after they have been released, prevent many others from entering the hospitals in the first place because they can be effectively treated by private practitioners.

One out of every 12 Americans will be hospitalized for mental illness at some time in his life. Half the hospital beds in the country are used for the treatment of such illness.

These statistics, while startling, give an extremely inadequate description of the suffering caused pa-

MENTAL HEALTH / Continued

tients and their families by mental illness. Probably no other disease so completely disrupts family life or is responsible for such intense distress over a long period of time. It has been estimated that the current cost of mental illness in this country is about \$2,500,000,000 a year. This figure includes both the direct cost in terms of patient care and the indirect cost in loss of earnings.

Many research problems, hitherto thought insoluble waited only for technologic progress. Many new tools and techniques are now used by psychiatric researchers: such as radioactive tracers, autoradiography, ultra sound, electronic brain exploration, fluorescent microscopy, color television, microscopy and micro-chemistry. Changing in step with psychiatry's "new look" is the public's attitude toward mental health. The lay press and other communication media have educated many Americans to regard mental disease as no longer shameful or hopeless.

There is little doubt that with the advent of the tranquilizer drugs mental hospitals have become more serene since physicians and nurses have been freed in most cases from the constant problems of restraint and sedation and medical care of patients. In many hospitals the tranquilizing drugs have supplanted shock therapy for agitated patients.

While the morale of patients, staff and families of the mentally ill has improved, so have pathways of communication between psychiatrists and patients.

Patients who had remained obstinately sunk in

apathy or mutism for years were found to take an interest in their surroundings and converse with coherence with psychiatrists.

One unforeseen practical dividend in the hospital use of tranquilizers is the saving of wear and tear on the plant, equipment, furnishings and clothing. Conversely more funds are frequently needed now for recreation facilities and occupational therapy equipment.

With the present tranquilizer drugs in use, the forecast is that while the population of mental hospitals may decline, the need for outpatient services will grow.

In the present day dynamic approach to psychiatry three main goals are set. Reduce the severity of symptoms through drugs or other therapeutic methods, establish communication between psychiatrists and patients across the dark boundaries of mental illness and seek the physiologic or biochemical factors that may cause or exacerbate symptoms.

The future lies in an integration between investigators in experimental medicine, biochemistry, nutrition, endocrinology, atomic physics. Breakdown of frontiers between these disciplines must lead to clearer common concepts, until recently obfuscated by specialized terminology. For the countless thousands who are or who may become mentally ill, today's light penetrating into the "obscure caverns" of the mind radiates genuine hope; for the medical and allied professions it illuminates widening breaches in one of medicine's most formidable barriers.

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

VENEREAL DISEASE ABSTRACTS AVAILABLE

Since 1957, infectious syphilis has been increasing at an alarming rate in all races, sexes, ages, social groups, and geographic areas. Physicians who have not observed a single case of infectious syphilis in 20 years suddenly are finding it among their patients.

Concurrent with this resurgence, unfortunately, is a paucity of venereal disease literature and information available to the private physician.

To partially alleviate this situation and serve a pressing need, the Venereal Disease Program of the Public Health Service routinely abstracts current articles on venereal diseases from almost 1,000 journals both

domestic and foreign. A publication entitled "Current Literature on Venereal Disease" including these abstracts is printed three or four times a year and indexed annually. It is distributed regularly free of charge to physicians on their personal request.

Any physician interested in receiving this publication may write to Communicable Disease Center, Atlanta 22, Georgia, Attention: Dr. William J. Brown, Chief, Venereal Disease Branch, requesting that their names be added to the mailing key for "Current Literature on Venereal Disease."



PRIMARY HYPERALDOSTERONISM, A CURABLE FORM OF HYPERTENSION

Francis W. Fitzhugh, Jr., M.D., *Atlanta*

IT IS CURRENTLY ESTIMATED that 20 per cent of all patients with elevated blood pressure have "secondary" hypertension. In some of these cases the cause of the hypertension can be eliminated, thereby resulting in complete and permanent cure. The other 80 per cent remain trapped under the heading of "primary" or "essential" hypertension. It is therefore important that the evaluation of every hypertensive patient include a thorough search for any removable cause.

One of the most recent entries into the field of curable secondary hypertension is primary hyperaldosteronism, first described in 1955 by Conn. Here the blood pressure elevation is due to production of excessive amounts of aldosterone by the adrenal cortex. Originally considered to be quite rare, it is being diagnosed with increasing frequency and already the literature contains reports of over a 100 proven cases. Fortunately, this disease usually presents as a relatively clear cut syndrome and its inclusion in the differential diagnosis need not appreciably complicate the work-up of the hypertensive patient.

The aldosterone era dates back to approximately 1950 when Deming and Luetscher, using bioassay methods, demonstrated a sodium-retaining material in extracts of urine from edematous patients. Within the next several years, this substance was isolated from extracts of the adrenal gland, crystallized, chemically identified, and given the name "aldosterone." Of the more than 30 crystalline steroids that have been identified in adrenal gland extracts, only a few have been shown to be released in appreciable amounts by the human adrenal gland. Cortisol (hydrocortisone) and corticosterone are released in relatively large amounts. Aldosterone is secreted in much smaller amounts. Unlike other

adrenocortical steroids, it is not governed by the adrenocorticotrophic hormone of the anterior pituitary. Its production is influenced primarily by intake of sodium and, to a lesser extent, potassium. Aldosterone activity in the body varies inversely with sodium intake and directly with potassium intake. It is by far the most potent mineralocorticoid, being more than 30 times as powerful as desoxycorticosterone acetate. It has only minimal effect on carbohydrate and protein metabolism and no anti-inflammatory effect.

Primary hyperaldosteronism, as the name implies, refers to overproduction of aldosterone caused by an abnormality of the adrenal cortex alone. In the majority of the reported cases a benign tumor of the adrenal cortex has been found to be the offending lesion. Other lesions found have been simple bilateral adrenal hyperplasia and an occasional malignant tumor. In secondary hyperaldosteronism, the adrenal cortex produces increased amounts of aldosterone in response to a disease which is primarily non-adrenal. Some, but not all, patients with edema due to congestive heart failure, nephrosis, cirrhosis, and toxemia of pregnancy have been shown to have secondary hyperaldosteronism. Interesting and as yet unexplained differences occur between primary and secondary hyperaldosteronism, as will be pointed out below.

The symptoms, signs, and laboratory findings in primary hyperaldosteronism may be grouped under two headings. First, there are the findings related to the hypertension itself. These do not vary from those found in patients with other types of hypertension except that the hypertension seems to be more apt to progress fairly rapidly to the malignant phase. It can be treated with anti-hypertensive drugs and seems to respond best to ganglionic blocking agents.

Why hypertension is not consistently found in secondary hyperaldosteronism remains a mystery. Secondly, and of greater interest, there are those findings which may be attributed to the changes in electrolyte metabolism. The excessive renal loss of potassium results in depletion of total body potassium which may be quite profound and is relatively refractory to attempts at correction. This potassium depletion in turn is responsible for the laboratory findings of hypokalemia, metabolic alkalosis, and alkaline urine. The characteristic electrocardiogram of potassium deficiency is usually seen. The potassium depletion is directly responsible for the periodic muscle weakness, most pronounced in the extremities, which is the most common and prominent presenting symptom in primary hyperaldosteronism. Indeed the microscopic picture of hypokalemic myopathy has been described. Paresthesias and tetany without hypocalcemia may also be attributed to the potassium depletion and the accompanying alkalosis. Potassium deficiency nephropathy can usually be demonstrated both microscopically and by disorders in renal function. Hyposthenuria, refractory to Pitressin administration, is characteristically present. As a result, polyuria and polydipsia are frequent complaints. All of the above findings quite logically may be accentuated by administration of the chlorothiazide drugs. The renal retention of sodium plays no known role in production of the symptomatology in primary aldosteronism. The serum sodium concentration, however, is usually slightly elevated. Edema is typically absent unless congestive heart

failure occurs. This remains unexplained—why does the edema occur in secondary hyperaldosteronism and not in primary?

The diagnosis of primary aldosteronism must be strongly suspected in any hypertensive patient who complains of muscle weakness, polyuria, and polydipsia, and who has a hypokalemic alkalosis. Helpful, but not necessary findings include paresthesias, tetany, and hypernatremia. When the diagnosis is strongly suspected, urine aldosterone determination must be performed. This remains a tedious and costly procedure and one which need not be done in the absence of weakness and hypokalemic alkalosis. The absence of these findings almost surely rules out the diagnosis of primary hyperaldosteronism.

When the diagnosis has been established, the treatment consists of surgical exploration of the adrenal glands. Prior to surgery, intravenous pyelography should be done in hopes of possibly localizing an adrenal tumor. Air contrast studies of the adrenal areas may be of value. If a cortical adenoma is found, it is removed. If bilateral adrenal hyperplasia is the offending lesion, total or extensive subtotal adrenalectomy is performed. In the majority of patients with primary hyperaldosteronism, complete and permanent cure may be expected.

To summarize, primary hyperaldosteronism is a surgically curable form of hypertension which may not be so rare as once considered. It must be strongly suspected in every hypertensive patient who complains of weakness and who presents a hypokalemic alkalosis type electrolyte pattern.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

KREBIOZEN EVALUATION

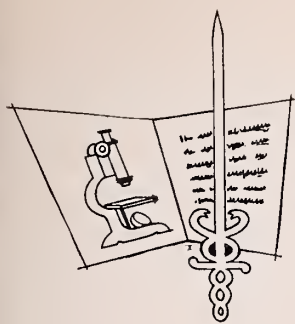
THE DEPARTMENT OF HEALTH, Education and Welfare has agreed to make an impartial evaluation of the controversial cancer drug Krebiozen.

U.S. District Judge Julius M. Miner, of Chicago, requested the evaluation before proceeding with a \$300,000 libel suit filed by Andrew C. Ivy, M.D., a leading endorser of the drug, against George D. Stoddard, Ph.D., chancellor of New York University and former president of the University of Illinois.

In a letter to HEW Secretary Ribicoff, Miner said:

"In my humble judgment, Krebiozen has too long been a controversial subject and the American public deserves that it be examined under neutral supervision and by the most competent experts in whom the people have implicit confidence."

Ribicoff said the National Cancer Institute would evaluate the drug when its sponsors presented the necessary data. But, he said, "any decision to undertake a study with human cancer patients must await, and depend on, the results of the evaluation of the existing clinical data."



CYTOTECHNOLOGY

John T. Godwin, M.D., *Atlanta*

CYTOTECHNOLOGY IS A RELATIVELY new facet of medical technology and has to do with the examination of exfoliated cells from various parts of the body.

Originally, Dr. George Papanicolaou first advocated the study of cervical and vaginal material by this method. Since this time, the technique of cytological examination has been applied to most organs of the body. The only organ which can be subjected readily and easily to routine examination is the uterus. Cytological study of this organ is now considered a requirement for the complete examination of all female patients, and has resulted in the examination of large numbers of cytological specimens. This has required an increased number of individuals qualified in this technique.

The study of cytological material may be compared to the examination of peripheral blood smears in which the medical technologist performs the initial study and submits all atypical smears to the pathologist for evaluation. Cytological preparations are handled in a similar fashion. In contrast to the hematology technologist, however, the technical training for cytological technologists requires a different and longer period.

The pre-technical training requirements are two years of college (90 quarter hours) including 18 quarter hours in biology.

The technical requirements are six months training in Cytology in a laboratory approved by the Committee on Cytotechnology of the American Society of Clinical Pathology and the Committee on Exfoliative Cytology of the College of American Pathologists. In addition, six months of full-time experience, in cytology, in an acceptable laboratory is required for certification as a cytotechnologist. This must be followed by the satisfactory completion of a written and practical examination.

Realizing the shortage of trained cytotechnologists, the Community Cancer Demonstration Project

Grant of the U. S. Public Health Service was inaugurated in order to augment the training of cytotechnologists. Twenty-two schools are now being supported to train these individuals. One of these schools is located in Atlanta and has trained 20 students and supplied hospitals of Atlanta and Georgia with cytotechnologists.

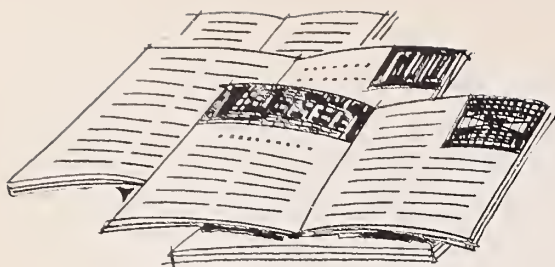
At the present time, the State of Georgia ranks eighth in total number of cytological specimens and third based on population to number of patients studied in 1960. Fifty-six pathologists in the State were surveyed of whom 82 per cent answered, reporting on 28 laboratories. The total number of specimens examined was 148,357. The study indicated that this number could be expanded to 316,730 in 1961.

There was an indication that four pathologists and 20 cytotechnologists are needed to augment the 19 cytotechnologists employed at the time of the survey.

The states exceeding Georgia in total number of cases studied in 1960 are in order: California — 656,736. New York State — 280,873. Ohio — 267,449. Texas — 242,975. Florida — 176,037. Tennessee — 170,828. Illinois — 163,613.

Throughout the country a total of 5,100,000 cases were examined in 1960, in 1,700 different laboratories. Presently, there are over 1,300 cytotechnologists employed in over 800 laboratories and there are 350 openings for cytotechnologists over the country. These figures certainly indicate the need for increasing the number of trainees in schools of cytotechnology particularly where vacancies exist at the present time. Attractive stipends of \$225 per month during the training period are available for qualified applicants. Unfortunately cytotechnology suffers the same problem as general medical technology, medicine, and other related fields in that there is severe competition for the properly motivated college student.

Approved by Professional Education Committee, Georgia Division, ASC.



Urine of Children with Sympathetic Tumors

FROM THIS REPORT it appears that not only the endocrine active pheochromocytomas, but also tumors arising from the ganglion cell series of the sympathetic nervous system lead to increased catecholamine metabolism. The determination of MHMA (3-methoxy-4-hydroxymandelic acid), a main breakdown product of epinephrine and norepinephrine, from patients with tumors of unknown type in childhood may prove to be a differential diagnostic criterion. A pathological increase in the absence of a clinical pheochromocytoma symptomatology would suggest the presence of an urine sympathetic tumor arising from the ganglion cell series.

Kaser, H., and Studnitz, W. vonfi Urine of Children with Sympathetic Tumors, *Am. P. Dis. Child.* 102:77, 1961.

Eye Involvement in Leukemia

OCULAR INVOLVEMENT was noted in at least 50 per cent of patients in this report who died of leukemia and allied disorders. The eye is affected four times more often in acute than chronic leukemia. Findings consisted largely of leukemia infiltrations and hemorrhages.

Allen, R. A., and Straatsma, R. B., Leukemia and Allied Disorders, *Arch. Ophthal.* 66:490, 1961.

Anemia in Leukemia

PATIENTS WITH DISSEMINATED neoplasms are frequently anemic, and hemolytic disease frequently contributes to the anemia. This study demonstrated that the in vitro autohemolytic phenomenon is not necessarily associated with a short RBC life span in vivo. This suggest that the abnormality of the plasma does not damage the RBC while they are in the circulation but may cause autohemolysis in vitro.

Crosby, W. H., Vullo, C., and Garriga, S., Hemolysis in Vitro in Acute Leukemia and the Anema of Leukemia, *Blood* 18:220, 1961.

Urinary Tract Infections of Chidhood

URINARY TRACT INFECTION in the female child is less frequently associated with obstructive uropathy than is the male child. None the less, complete investigation is necessary in both sexes including urinalysis,

urine culture, and where indicated excretory urograms, cystogram and cystoscopy.

Robert H. Owens, and James F. O'Malley
Southern Medical Journal
Vol. 54, No. 10: October, 1961

Management of Exstrophy of the Urinary Bladder by Primary Closure

THE EXSTROPHIC BLADDER which has good musculature can be satisfactorily closed, and an acceptable functional continent result can be anticipated if primary closure of the defect is limited to those with the large bladder capacity.

Ian M. Thompson

Southern Medical Journal
Vol. 54, No. 10: October, 1961

Tangier Disease

"THUS, WE HAVE two young siblings with tonsils of extraordinary size and appearance, enlargement of the liver, spleen, and lymph nodes, and hypocholesterolemia. These findings are related to the presence of reticulo endothelial cells laden with very large amounts of cholesterol esters and the complete, or almost complete, absence of plasma *a* or high density lipoproteins. To my knowledge such deficiency or high density lipoproteins has never been reported. The specific accumulation of cholesterol esters in tissues is also unusual, for several different lipid classes tend to be elevated in most other instances of tissue lipid storage. Hence, we are apparently dealing with a new disease; and the available data suggests it is a genetically determined one. Until the disease can be described in terms of the basic defect, we have chosen to call it simply 'Tangier disease.'"

Tangier Disease—Combined Clinical Staff Conference at the National Institutes of Health—*Ann. Int. Med.* 55:1016, 1961.

Etiology of Human Atheroma

"EVIDENCE FROM histochemical studies of both animal and human aortas suggests that in the production of atheroma, the arteriole wall itself probably synthesizes the fat and some of the cholesterol that accumulates in these lesions, and that the factor which initiates this process might be a deficiency of

polyunsaturated fatty acids. A deficiency of ATP-ase in a specific site would disturb the balance of ATP production and destruction and permit this compound to accumulate. Thus, the lipid constituents of atheroma could accumulate in the same area for the same reason. It is possible, once the pre-atheromatous change in the aortic wall has occurred, that high blood cholesterol levels may result in some of this material penetrating the wall and becoming deposited there, in which case it represents only a contributing and not the initiating factor. This theory reconciles the anomalies which exist between serum cholesterol levels and incidence of atheroma."

Sander, M., and Bourne, G. H.: "Some New Observations on Human Aortic Atheroma"—J.A.M.A. 179:43, 1962.

Pre-eclampsia and Permanent Hypertension

"THE FINDINGS support the view that pre-eclampsia is not a direct cause of hypertension in later life. In some women diagnosed as having mild pre-eclampsia the rise in blood pressure may represent the temporary unmasking during pregnancy of a hypertensive tendency which subsides after the delivery but returns in later life. The proportion of women with severe pre-eclampsia who have this hypertensive tendency is no greater than average."

Adams, E. B., and MacGillivray, I. Long-term Effect of Pre-eclampsia on Blood Pressure—LANCET 2:1373, 1961.

Hyperparathyroidism

MANY DEMINERALIZING diseases can be differentiated by the absence of hypercalcemia: osteoporosis, osteomalacia, fibrous dysplasia, Paget's Disease, and renal osteodystrophy. Malignant disease is perhaps the commonest cause of hypercalcemia rather than hyperparathyroidism. Hypophosphatemia is not a reliable means of differentiating hyperparathyroidism from other causes of hypercalcemia. Response to cortisone by a fall of serum calcium to normal has been consistent and decisive in sarcoidosis, hypervitaminosis D, and myeloma, but the possibility of an occasional false-positive response in hyperparathyroidism must not be forgotten. Hyperfunctioning parathyroid lesions have been demonstrated in patients with metastatic carcinoma, myeloma, sarcoidosis, milk-alkali syndrome, Paget's Disease, hyperthyroidism.

Keating, F. R., Jr.: Diagnosis of Primary Hyperthyroidism. Clinical and Laboratory Aspects, J.A.M.A. 178:547-555, 1961.

Function of the Basophil

"STUDIES HAVE been presented showing that post-prandial lipemia is specifically associated with de-

granulation of the basophil in man. This basophil degranulation is viewed as a mechanism for the physiologic release of heparin and hence the initiation of the clearing reaction. It has been suggested that lecithinase A could be a physiologic agent responsible for such basophilic degranulation."

Shelley, W. D., and Guhlin, L.: "Degranulation of the Basophil in Man Induced by Alimentary Lipemia"—Trans. Assoc. Amer. Physicians 74:118, 1961.

Elevated Serum PBI without Hyperthyroidism

"A HEREDITARY INCREASE in the thyroxin-binding sites in serum α globulin has been described. An otherwise unexplained elevation of the serum PBI is the usual clue that this defect exists in a patient."

Beierwaltes, W. H., Carr, E. A., Jr., and Hunter, R. L. Hereditary Increase in the Thyroxin-Binding Sites in the Serum & Globulin—Trans. Assoc. Amer. Physicians. 74:170, 1961.

Hypertension and the Nervous System

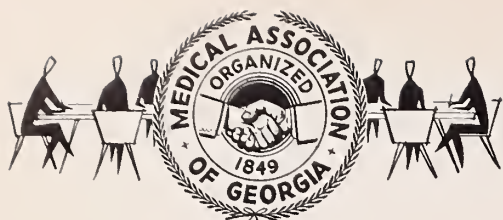
NEUROLOGICAL DISEASE in the hypertensive is more likely to be the result rather than the cause of the blood pressure elevation, except in very circumscribed situations. At present there are no experimental data to support a hypothesis that chronic blood pressure elevations are due to primary organic changes in the central nervous system. Well documented examples of sustained hypertension due to a recognized neurologic condition in the absence of the above states has not as yet been reported.

Tyler, H. R., and Dawson, D.: Hypertension and its Relation to the Nervous System. Ann. Int. Med. 55:681-694, 1961.

Beryllium Disease

"DIFFERENTIAL DIAGNOSIS between beryllium disease and sarcoidosis, the most difficult diagnostic problem, at present rests on the establishment of beryllium exposure. However, there remain several striking differences between the two diseases although further experience with the occupational illness may alter these. There is no change in reaction to tuberculin as in sarcoidosis. No eye, tonsil, parotid, or cystic bone lesions have as yet been reported in the chemical intoxication and no case of beryllium poisoning with hilar adenopathy alone has been reported. Increase in knowledge of both sarcoidosis and beryllium disease may alter the present fact that the former appears to carry a better prognosis and more favorable, lasting response to steroids."

Hardy, H. L.—Beryllium Disease: A continuing diagnostic Problem—Trans. Assoc. Amer. Physicians 74:333, 1961.



THE ASSOCIATION

PERSONALS

First District

WILLIAM D. WILSON of Savannah was recently elected president of the Hospital Service Association.

LOUIE H. GRIFFIN of Claxton, in February, completed a postgraduate course, "Obstetric Problems in Private Practice" at the Medical College of Georgia.

Second District

No news submitted.

Third District

Three Columbus doctors, GEORGE WHATLEY, JULIAN SIZEMORE and JOSEPH SERRATO, were featured on a special March of Dimes television show in January.

Fourth District

No news submitted.

Fifth District

WALKER L. CURTIS of Atlanta was one of the two men honored by the Inter-City Civitan Club as having contributed most to the building of better citizenship in their community.

NEEDHAM B. BATEMAN of Atlanta has been added to the board of directors of the *Atlanta Times, Inc.*, Georgia's proposed new daily newspaper.

Sixth District

No news submitted.

Seventh District

DONALD R. THOMAS of Dalton recently completed a postgraduate course, "Obstetric Problems in Private Practice," held at the Medical College of Georgia in Augusta.

SARA GOOLSBY of Rossville recently announced the opening of her office for the practice of medicine with her husband, J. P. HOOVER.

THOMAS W. ALSOBROOK of Rossville was recently elected Chief of the Medical Staff of John L. Hutcheson Memorial Tri-County Hospital for 1962. Serving with him are: T. E. ADKINS vice chief and LEROY SHERRILL, secretary.

Eighth District

Y. F. CARTER, JR. of Nashville recently attended a postgraduate course, "Obstetric Problems in Private Practice" at the Medical College of Georgia in Augusta.

J. B. OLIPHANT of Adel was named in January as the president of the Farmers and Merchants Bank.

Ninth District

C.. B. WATKINS of Ellijay recently attended a postgraduate course, "Obstetric Problems in Private Practice" at the Medical College of Georgia in Augusta.

Tenth District

FREDERICK P. ZUSPAN of Augusta was awarded in January, the National Foundation Prize of the South Atlantic Association of Obstetricians and Gynecologists for preparation of a thesis on problems relating to pregnancy and stillbirth.

SHANNON GALLAGHER and MELVIS CORBITT of Augusta were guest speakers recently at the local Pilot Club.

CHARLES E. WILLS, JR. of Washington recently attended the postgraduate course, "Obstetric Problems in Private Practice," held at the Medical College of Georgia in Augusta.

SOCIETIES

Athens Banner-Herald recently published an article on the history of CRAWFORD LONG MEDICAL SOCIETY and listed their present members.

GLYNN COUNTY MEDICAL SOCIETY held its regular monthly meeting during the latter part of January and had a panel of speakers from St. Vincent Hospital in Jacksonville, Florida, speak to them on the problems of muscular dystrophy. The group included Drs. Merrell Whorton, pathologist; Paul Hudgins, biochemist and Jim Connors, orthopedist.

POLK COUNTY MEDICAL SOCIETY recently heard Mrs. Alice Bennett, director of the Polk County Welfare Department speak. Discussion centered around the new Kerr-Mills Law.

WALKER-CATOOSA-DADE MEDICAL SOCIETY recently met and discussed the King-Anderson bill.

The GEORGIA MEDICAL SOCIETY met in February. The program was entitled "Tax Symposium" and speakers were Mr. Lamar Davis, Mr. Walter Rhoads and Mr. Irwin Mazo.

SPECIAL CALLED MEETING EXECUTIVE COMMITTEE OF COUNCIL

THE EXECUTIVE COMMITTEE of Council Special Meeting was called to order at 10:00 a.m., January 28, 1962, by Chairman Fred H. Simonton.

Members of the Executive Committee present were Fred H. Simonton, Chickamauga; Thomas W. Goodwin, Augusta; George H. Alexander, Forsyth; Milford B. Hatcher, Macon; J. G. McDaniel, Atlanta; Linton H. Bishop, Atlanta, and John T. Mauldin,

Atlanta. Also attending the meeting were John S. Atwater, Atlanta; Robert L. Bennett, Warm Springs; John Venable and Cliff Rutland, representing the State Department of Health; and Mr. John Moore, MAG Attorney. Staff members present were Mr. James M. Moffett and Mrs. Catherine Wooten.

Proposed Vocational Rehabilitation Center, Warm Springs

Robert L. Bennett, Warm Springs Foundation Director, gave the Executive Committee information regarding a proposed Vocational Rehabilitation Center to be constructed adjacent to the Foundation. He believes a technical training school for the purpose of training physically handicapped and mentally retarded people would be advantageous. He stated that Warm Springs could accept medical responsibility, that is, the trainees could be evaluated by a committee of doctors and therapists. A 300 bed dormitory center would be necessary to house these trainees. It was suggested by Executive Committee that Dr. Bennett hold a meeting of his Sub-Committee on Rehabilitation before the next Executive Committee on February 18th to ascertain the opinion of his sub-committee about this proposal; and to make a report to the Executive Committee on February 18th. On motion duly made and seconded it was voted to refer the matter of the proposed Vocational Rehabilitation Center at Warm Springs to the Sub-Committee on Rehabilitation for recommendation.

Non-Citizen Physician Practice

Mr. Moffett stated that Mr. Harry Dicus, State Representative, had been asked to consider introducing a bill to permit a non-citizen physician to be employed by a company or other private interest for the purpose of permitting such person to serve as a medical director for such company, and wanted MAG approval or disapproval. On motion (Goodwin-Alexander) it was voted to disapprove the introduction of such a bill and to so notify Mr. Dicus.

Recodification of Georgia Public Health Laws

Dr. Venable made a few introductory remarks before the reading of the recodification. Chairman Simonton then read each Chapter by number, and there were only two suggested changes, as follows:

(1) Chapter 88-4: 88-402 *Definitions*. Physician should be designated as one licensed to practice under Georgia Medical Practice Act (Georgia Code Chapter 84-9).

(1) Chapter 88-19: 88-1903 *Creation of hospital authorities*. The Chief of Staff should be on the Board of Trustees of the hospital governing board.

No action was taken on the above suggested changes after discussion by the Executive Committee. On motion (Mauldin-Hatcher) it was voted to accept the recodification of the Public Health Laws as presented.

Dr. Venable asked for a MAG representative at the Tuesday, January 30th hearing to give the MAG decision on the above laws.

MAA Program Expense

It was recommended by Executive Committee that any reimbursable expenses in connection with bookkeeping should be put into the Contingent Fund.

There being no further business the meeting was adjourned at 2:35 p.m.

**MEDICAL ASSOCIATION OF GEORGIA
COMMITTEE ON CANCER MEETING
MINUTES**

MEETING WAS CALLED to order by Chairman, Vice Chairman Dr. Frank Walker and Dr. Robert Pendergrass. Those present were Dr. M. V. Murphy, Dr. Everett L. Bishop, Dr. Ralph Davis, Dr. Robert L. Brown, Dr. Hoke Wammock, Dr. John Venable and Dr. John Mauldin.

Dr. Murphy stated that Mr. Ed Bridges, from the Governor's office, told Dr. John Venable that the Governor would make additional money available to operate the cancer program for the rest of the year provided that some sort of an agreement could be reached assuring the Governor that no additional funds would be asked for the following year. This means that the budget would be \$400,000 next year with no additional funds.

This matter was discussed and it was decided to do two things, one, call a meeting of Clinic Directors and Hospital Administrators in order to discuss this problem and two, change rules and regulations of program in order to tighten up on admissions and longevity in the hospital.

It was recommended that the following factors be considered in these changes:

- (1) Reclassification of policy of certification and recertification.
 - (a) Explore the possibilities for part-payment by those patients who could afford it.
- (2) Revise the rules for hospital admission.
- (3) Revise the rules for re-admission for all patients.
- (4) Rules for transferring patients from clinic to clinic.
- (5) Policy on out-patient procedures.
- (6) Any others that might be thought to be practical.

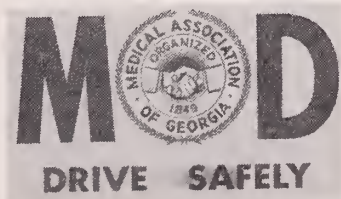
Chairman Wammock appointed a Committee consisting of Drs. Bishop, Brown and Mauldin to work with Dr. Murphy in revising these rules.

The following policy statement was accepted by the Committee: To recommend that the pursestrings be tightened by re-evaluation of admission and treatment policies in an effort to alleviate undue stress and the possibility of requesting additional money.

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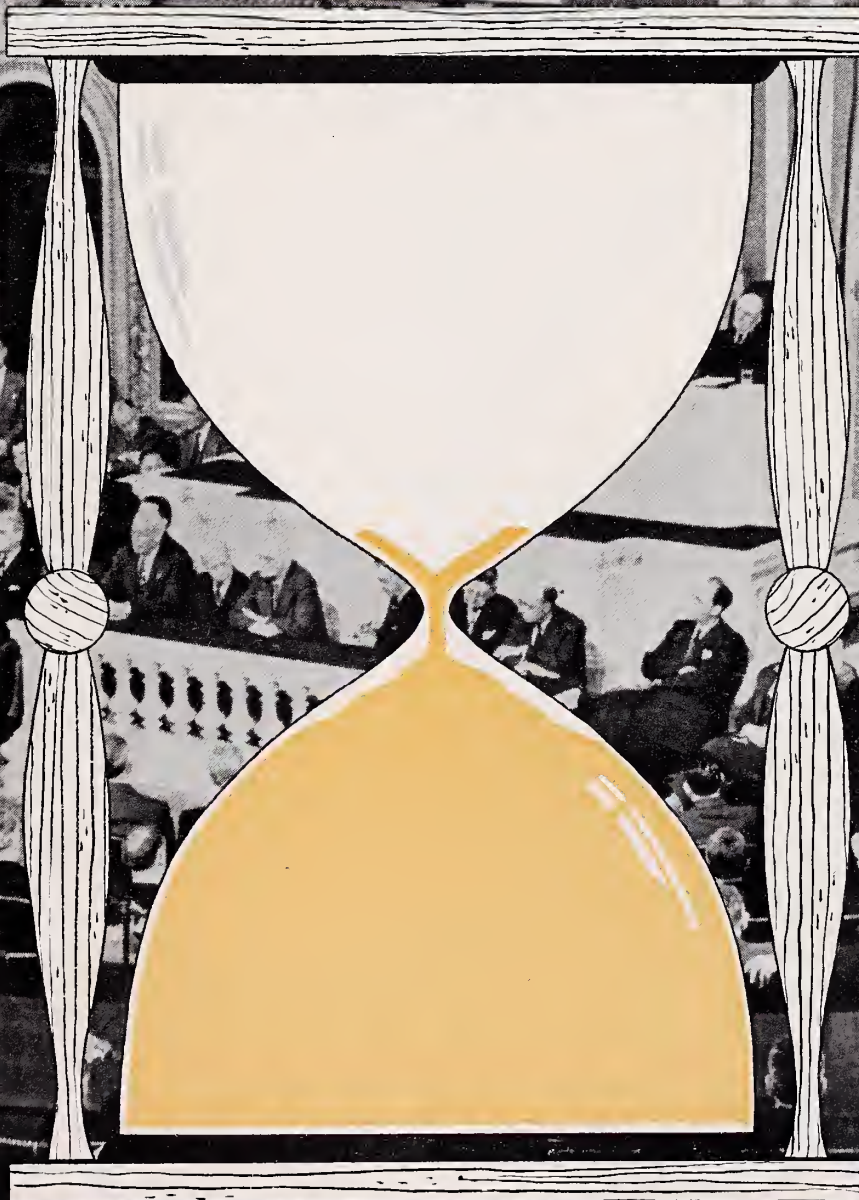
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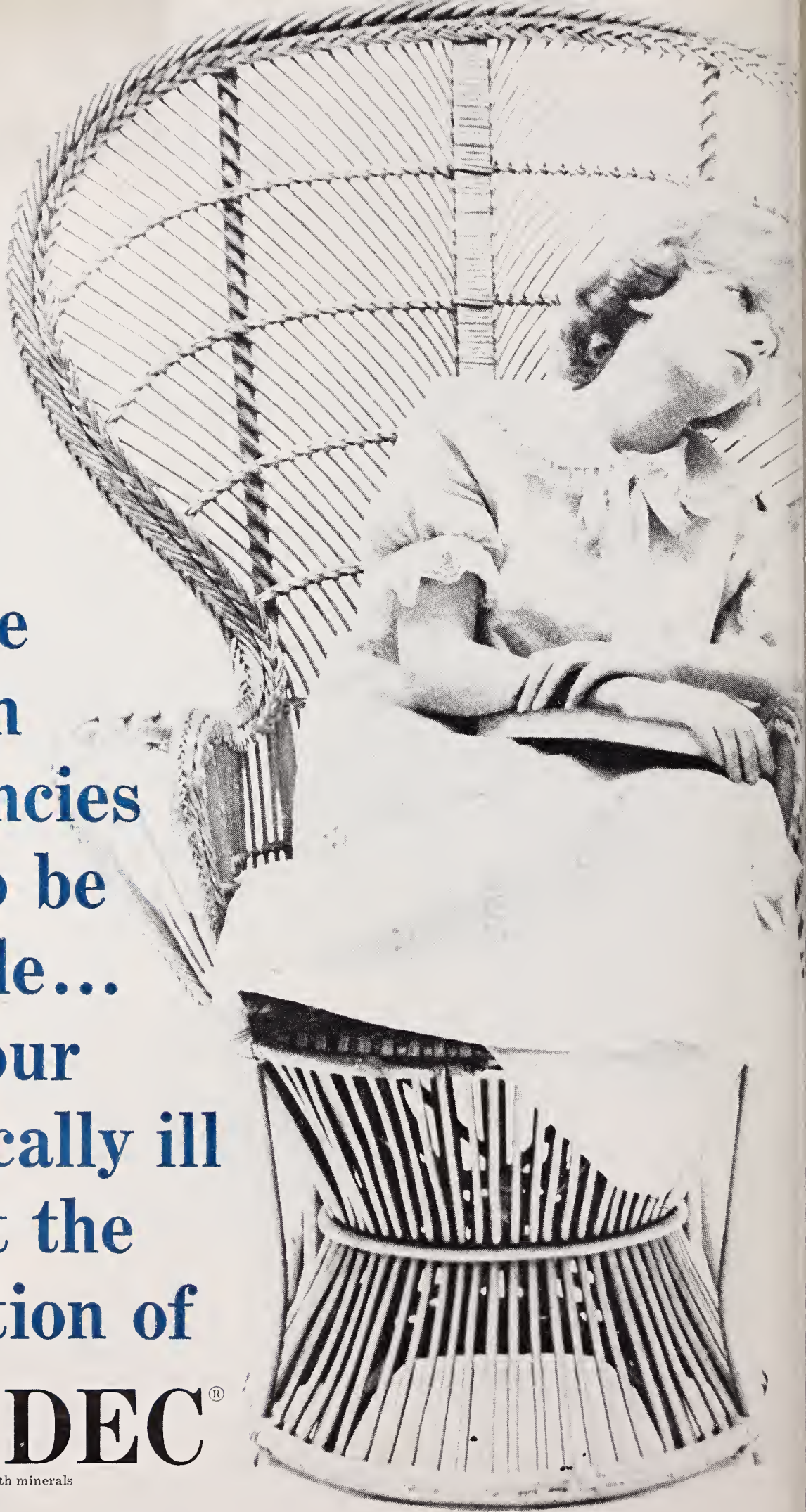


THE TIME FOR DECISION IS NEAR

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SURGICAL TREATMENT OF ISOLATED PULMONIC VALVULAR AND INFUNDIBULAR STENOSIS USING EXTRACORPOREAL CIRCULATION

Richard King, M.D., James B. Minor, M.D., M. Bedford Davis, Jr., M.D., William A. Hopkins, M.D., William C. Wansker, M.D., and Lester Rumble, Jr., M.D., *Atlanta*

■ *This method is the procedure of choice in the majority of cases*

THREE SURGICAL METHODS have been developed and used successfully in correcting pulmonic valvular and infundibular stenosis. The indirect approach for surgical relief of a stenotic pulmonary valve was performed first by Sellors¹⁰ in December 1947. This successful case was followed in 1948 with case reports by Brock.⁴ Dodrill in 1953 advocated the open method of correction by using the mechanical heart-lung machine and by-passing the right heart completely and reported one case.⁵ With the development of hypothermia and inflow occlusion of the vena cavae, Swan popularized the direct approach by opening the pulmonary artery to correct pulmonic valvular stenosis and ventriculotomy for isolated infundibular stenosis.¹¹ With further refinement of extracorporeal circulation, complete by-pass of the heart has been advocated for a direct open attack on pulmonic stenosis. We feel that the latter approach is the best one and report upon its use in 11 cases of pulmonic valvular and infundibular stenosis.

Embryology

In order to comprehend pulmonic stenosis the developmental anatomy of the right ventricle must be reviewed. The primitive heart tube is essentially straight and is composed of five chambers; (1) the sinus venosus caudally, (2) the primitive atrium,

(3) the primitive ventricle, (4) the bulbus, and (5) the truncus arteriosus. The heart tube grows rapidly, so that it first bends ventrally to form a U-loop. Then it twists upon itself. The bend in the U-loop becomes the common ventricle and lies inferior to the atrium. The bulbus fuses with the adjacent primitive ventricle, its chamber at first partly separated from it by a double wall or muscular partition (derived from the two intervening infolded walls of the cardiac tube). This muscular partition undergoes involution until it remains only as a rudimentary ridge located upon the dorsal wall of the lumen of the right ventricle — the supraventricular crest. The interventricular septum then develops to divide the common ventricle into the right and the left ventricular chambers. If there is incomplete involution of the bulbus cordis it results in an infundibular chamber and obstruction to the outflow tract of the right ventricle. The division of the truncus arteriosus into aorta and pulmonary artery begins with the development of paired ridges which gradually grow inward to meet in the midline, progressively dividing the vessel into aorta and pulmonary artery. The ridges extend in a clockwise spiral fashion downward to the conus or bulbus toward the interventricular septum and make a 270 degree turn. The spiral course brings the aortic ostium around to the outlet of the left ventricle and the pulmonic outlet to the right ventricle.^{1, 7}

"The truncus arteriosus, the single vessel that conveys blood from the primitive heart, is divided

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STENOSIS / Continued

into its two final components by the development of two prominent ridge-like thickenings of its endocardial lining; these ridges, the right and left spiral ridges, fuse to form the aortopulmonary septum which divides the unabsorbed part of the bulbus into an aortic and a pulmonary trunk. Below this spiral septum four endocardial cushions form in the distal part of the bulbus cordis near its junction with the truncus; the right and left cushions fuse together to form a septum (the distal bulbar septum) with which the spiral septum fuses, thus further completing the division between the aorta and the pulmonary artery."³

"The right ventricle consists of two portions, a proximal or inflow portion — the sinus; a distal or outflow portion — the infundibulum. Between these two parts is a muscular constriction formed, in the root, by a large projection, the crista supraventricularis; important connections pass from this to the right wall and to the septal wall and so down to the apical musculature. The infundibulum is developed from the bulbus cordis which, first of all a narrow passage, enlarges or expands and is then overwhelmed by a growth of the ventricular muscle into it. The stage of formation of the bulbus cordis and its fusion into the right ventricle and the truncus arteriosus is seen for a short time in the human embryo. A well-formed bulbus cordis is a normal constituent of the heart of the gill-breathing fish. Distally the bulbus tissue forms the pulmonary valves and first part of the pulmonary artery, the so-called arterial root. The development of the infundibulum and the inclusion of the bulbus cordis is intimately concerned with the closure of the ventricular septum."³

Pathology

The most common type of obstruction to the pulmonary artery is pulmonic valvular stenosis in which the valves are fused and form a dome shaped diaphragm projecting into the pulmonary artery. The second type of obstruction is that of isolated infundibular stenosis which consists of a narrowing of the infundibulum or a localized stenosis of the infundibulum located at different levels proximal to the valve. The third type of obstruction is a combination of valvular stenosis and infundibular stenosis. The infundibular cavity may be markedly dilated above the constriction or it may be small with thick muscular walls.

Symptoms

Symptomatology of pulmonary stenosis varies from mild to severe. In the milder form there may be no symptoms until the patient reaches his teens

and sometimes late adult life. There may be no symptoms at rest, but usually exertion will produce dyspnea, fatigability, syncope, dizziness, anginal pain, and eventually edema and right heart failure.¹¹

Physical Findings

The most outstanding physical finding is the presence of a very loud, harsh murmur, usually accompanied by a thrill, systolic in time, which is most common in the second or third interspace to the left of the sternum. The second pulmonic sound is either diminished or absent. The main differential point between valvular stenosis and infundibular stenosis is the maximal intensity of the thrill and systolic murmur in the third left intercostal space, but higher up in valvular stenosis.² This was a constant finding in the cases reported by Swan.¹¹ Prominent A waves may be visible in the neck.

Electrocardiogram

The electrocardiogram reveals a right axis deviation and either a right ventricular hypertrophy or a right bundle branch block. Following ventriculotomy right bundle branch block may be produced; however, in the regression of right ventricular hypertrophy to normal, the pattern of right bundle branch block may be seen. If right bundle branch block is not present prior to surgery and is seen immediately after surgery, one may conclude that it is secondary to ventriculotomy.

X-Ray Studies

The roentgenologic studies will reveal the right ventricle is enlarged usually in both valvular and infundibular stenosis. There is an enlargement of the pulmonary artery in the majority of cases of valvular stenosis due to poststenotic dilatation, but this is rarely ever present in infundibular stenosis. There is a diminished pulsation in the pulmonary artery and its branches as well as in the hili of the lungs. The right atrium usually is enlarged in pulmonic stenosis when the ventricular septum is intact.

Angiocardiography

"Angiocardiography has a special niche in the study of pulmonic stenosis since it may give visual evidence of the site of obstruction. It is useful as a separate method of investigation in these cases, but it is also helpful when used as an adjunct to cardiac catheterization, especially in selective angiocardiography when the injection is made with the catheter in a particular chamber of the heart. Perhaps the chief value of angiocardiography in pulmonic stenosis lies in the first few weeks or months before the usual diagnostic features of these congenital defects have had time to develop."⁸ It has been most useful in

clarifying the problem of pulmonic stenosis, especially where associated defects are present.

Catheterization

Preoperative catheterization studies should be obtained when pulmonic stenosis is suspected, to help make an accurate diagnosis. If the systolic pressure is low in the pulmonary artery and there is an abrupt change to a high pressure proximal to the valve when the catheter is pulled back through the valve it indicates the presence of pulmonic valvular stenosis. If there is an intermediate zone of pressure in the outflow tract of the right ventricle with a further sharp rise in systolic pressure, as the catheter is pulled back, this indicates the presence of an infundibular stenosis. Kirklin⁹ has stated that a sudden transition from pulmonary artery to ventricular pressure can occur not only in valvular

stenosis, but also in pure infundibular stenosis if the obstruction is situated close to the valve.

Discussion

The use of complete cardiopulmonary by-pass using a heart-lung machine is certainly the procedure of choice in the majority of cases of pulmonary stenosis. Only in the critically ill infant or small child, when an emergency procedure is necessary, is closed valvulotomy indicated. Definitive surgery cannot be performed unless the surgeon can see what he is doing. Where there are associated defects such as atrial and interventricular septal defects, the advantage definitely lies with the open approach and total cardiopulmonary by-pass. Sometimes the intermediate zone of pressure in the outflow tract, or infundibular chamber, cannot always be demonstrated even in some severe cases of infundibular

PRESSURES MM. HG

PREOPERATIVE				POSTOPERATIVE			
PATIENT	R.V.	Outflow Tract	P.A.	R.V.	Outflow Tract	P.A.	RESULT

V.I.B. Age: 9 Oct. 16, 1958	116/6		(Right) M=8.5	May 26, 1959 31/4		(Main) 15/6	Excellent
K.B. Age: 8 Oct. 30, 1958	168/8		(Right) M=7	Feb. 5, 1960 22/3	11/3	(Main) 11/4 (6)	Excellent
J.N.B. Age: 16 May 11, 1960	105/7		(Main) 14/6 (Right) (8.5)	Not Yet Done			Excellent
B.A.G. Age: 9 April 4, 1956	52/0		13/0	April 2, 1959 26/0		19/9	Excellent
J.L.M. Age: 4 Oct. 22, 1958	112/7		(Main) 16/8 (Right) M=10.5	July 7, 1959 30/0		30/18	Excellent
W.M.M. Age: 33 Dec. 31, 1957	103/7	92/7	9	Not Yet Done			Excellent
C.D.P. Age: 6 Sept. 18, 1957 Sept. 11, 1958	60/0 93/0		P.A. could not be entered. (Main) 18/5 (5)	July 13, 1960 31/3		(Main) 16/5	Excellent
J.S. Age: 8 April 28, 1960	80/2		10/5	Not Yet Done			Excellent
W.M.S., Jr. Age: 40 Aug. 29, 1956	115/0		13/7	Not Yet Done			Excellent
C.T. Age: 34 Sept. 10, 1959	(Mid.) 51/0	12/0	15/6	Feb. 23, 1960 54/0		15/6	Excellent
B.T. Age: 7 Aug. 11, 1959	99/6	25/4	25/10 (15)	Sept. 29, 1960 50/4		30/10 (17)	Excellent

STENOSIS / Continued

stenosis. This is another indication for ventriculotomy and complete cardiopulmonary by-pass. This gives the surgeon adequate time for an accurate appraisal of the pathology present. The interventricular septum can be thoroughly examined and this is important because a small septal defect cannot always be detected by catheterization. In one of our cases, preoperative catheterization revealed a systolic pressure of 116 mm. of Hg in the right ventricle with no intermediate change of the pressure in the outflow tract and a pulmonary artery pressure of 8.5 mm. of Hg. After placing the patient on cardiopulmonary by-pass a pulmonary arteriotomy was first performed thinking that a pulmonic valvular stenosis was present. This was not the problem because the child instead had a severe infundibular stenosis. A satisfactory infundibulectomy was performed, so that there was an adequate outflow tract. Catheterization one and one-half years later revealed a systolic pressure of 31 mm. of Hg. in the right ventricle and of 15 mm. of Hg in the pulmonary artery. Brock³ has shown that infundibular hypertrophy may cause obstruction to the right ventricular emptying after relief of valvular stenosis, for when there is no obstruction to push against, the infundibular walls contract together more quickly and completely. According to Gerbode⁶ there is still another factor acting in some instances. "Pulmonary valvulotomy may cause a valve incompetence which permits regurgitation of blood into the right ventricle during diastole. This regurgitant flow adds to the amount of blood which may be trapped in the right ventricle by the contraction of the infundibular stenosis early in systole."

In some cases, after surgical correction, the ventricular pressure may be higher than normal due to hypertrophy but later catheterization studies will show a decrease in right ventricular pressure to normal, indicating a regression of the "work hypertrophy." This will occur sometimes even after surgical correction using cardiopulmonary by-pass.

We feel that whenever the right ventricular pressure is 70 mm. of Hg or greater, this is an indication for surgery. Some of the cases will have lower pressures and the ones in this category who are having definite symptoms should be corrected surgically.

Surgical Technique

The Kay-Cross Disc Oxygenator was used in all the cases. Exposure was obtained either through a sternal splitting incision or a transthoracic thoracotomy through the fourth intercostal spaces and across the sternum. After opening the pericardial

sac widely the heart was thoroughly inspected. After placing a purse-string suture in the right auricular appendage and incising the tip, the index finger is inserted into the right atrium to determine if an auricular septal defect is present, and then passed through the tricuspid valve through the outflow tract and to and sometimes through the pulmonary valve. We found this maneuver to be an excellent diagnostic aid in determining the presence of valvular and sometimes infundibular stenosis. Catheters are then inserted through the auricular appendage into the superior and inferior vena cavae.

In the meantime a cannula was being inserted into the femoral artery for the return flow of oxygenated blood. Then the patient is placed on complete by-pass and in the case of valvular stenosis the pulmonary artery is opened for three or four cm. and the commissures of the valve cut under direct vision. The arteriotomy is then enclosed with silk and a ventriculotomy is performed to correct an infundibular stenosis. Gerbode⁶ recommends the use of ventriculotomy to be absolutely sure about the presence of an infundibular chamber or an obstructive "work hypertrophy" of the ventricular wall. He then grasps the stenotic pulmonary valve, inverts it, cuts out the thick central portion and divides the valve. The incision in the ventricle is then closed with two layers of silk. Pressures are measured both before opening the pulmonary artery, or the right ventricle, and after the incisions have been closed to determine if there is a satisfactory gradient across the outflow tract and pulmonary valve. The patient is then taken off by-pass and the pericardium closed loosely with interrupted silk sutures. One catheter is usually left in the anterior mediastinum and one in the right posterior chest cavity for adequate drainage and also in the left chest cavity if the pleura is opened on that side.

Summary

The three surgical methods which have been developed and used successfully in correcting pulmonic valvular stenosis are the following: Indirect approach by the closed method, hypothermia and inflow occlusion of the vena cavae, and extracorporeal circulation using a heart-lung machine. The embryologic development revealed that incomplete involution of the bulbus cordis results in an infundibular chamber and obstruction to the outflow tract of the right ventricle. Pathology revealed that there are three types of obstruction to the pulmonary artery and the first and most common is pulmonic valvular stenosis; second, infundibular stenosis which has a number of variations; and the third is a combination of the first and second. A brief review of the symptoms, physical findings,

electrocardiography, and x-ray studies have been presented. The importance of angiocardiology and catheterization studies prior to surgery has been emphasized. A number of reasons for using complete cardiopulmonary by-pass in pulmonary valvular stenosis have been listed.

1938 Peachtree Road

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GEORGIA PATHOLOGISTS PRINCIPLES OF PRACTICE

In order to acquaint physicians with the principles and ethical practice of pathology, the following Statement of Principles is being published. This will be followed by publication of the Code of Ethics of the College of American Pathologists and later by the Code of Ethics of the American Society of Clinical Pathologists.

It is hoped that by publishing these three statements that physicians may be better able to judge and select pathologists and laboratory services consistent with the ethical principles established for guiding pathologists.

Georgia Association of Pathologists

Statement of Principles Relating to the Practice of Pathology

1. WHEREAS, The practice of Pathology is defined as pathologic anatomy and clinical pathology, including such subdivisions as clinical chemistry, clinical microbiology, hematology, diagnostic radioisotopes, exfoliative cytology, blood banking, clinical microscopy, and other related disciplines, *and*
2. WHEREAS, Pathology is recognized as the practice of medicine by statutes of various states, courts of law, and organizations such as the American Medical Association and the College of American Pathologists, *and*
3. WHEREAS, Pathology is a medical specialty which has certain technical aspects that carry integral professional responsibilities and are not separable into professional and technical divisions, *and*
4. WHEREAS, Physicians engaged in the practice of pathology are obliged to adhere to the same legal and ethical requirements as other physicians, *and*
5. WHEREAS, Control by nonmedical persons of the

practice of medicine as it relates to pathology is not in the best interests of the patient or the public good, *and*

6. WHEREAS, Health Insurance Contracts designate certain services as medical services and certain services as hospital services; *Therefore, be it*
1. *Resolved*, That contracts or agreements between pathologists and institutions must be in accord with the requirements of law and with the codes of ethics and statements of principles of the American Medical Association and of the College of American Pathologists; *and be it further*
2. *Resolved*, That such contracts or agreements must preclude the sale of the services of a pathologist by institutions, organizations of such services; *and be it further*
3. *Resolved*, That fees for the services of a pathologist are not separable, and must include all costs incident to the provision of such services; *and be it further*
4. *Resolved*, That pathologic services shall be included in Medical Service Contracts and shall not be provided in Hospital Service Contracts; *and be it further*
5. *Resolved*, That fees for the services of a pathologist must be collected in the name of pathologist either by him or by the institution or other agent designated by him as his collecting agent, and that the service must be properly identified to the patient as a Medical Service; *and be it finally*
6. *Resolved*, That the pathologist may be remunerated for his services to patients, for research, or for teaching, by governmental or other institutions, provided no fee is charged for such services by that institution.

WHY THE PROFESSION MUST HAVE A PUBLIC VOICE

Congressman Bruce Alger, *Dallas, Texas*

THE DOCTORS OF GEORGIA, like their fellows in every State of the Union, have a calling today above and beyond the honored practice of medicine. In addition to the dedicated task of healing the sick and comforting the suffering, you must be in the front line troops in the battle to save America and the free competitive system. There is meaning in the title which has been given to these remarks, "Pitching the Facts at the Public." Unless the American people have the facts, unless they are aroused by the facts, the freedom of mankind may be lost. No group is in a better position to inform and arouse patriotic Americans than are you.

Time is running out for free America and the free world. We may be measuring time in a matter of months as the period we have to save this Republic. The evil forces let loose in the world by the Communist conspiracy are converging on the United States of America and, unless we defeat them, liberty must perish and this once proud nation of free men will be no more. With the destruction of America, so will be destroyed the last pure hope of free men everywhere.

Before I give you the bill of particulars on the challenge we face, let me take just 30 seconds to compliment the medical profession for the contributions you have made and continue to make to help create a better life for all our people. In addition to

the high quality of professional service you render, you have made notable contributions in presenting valuable studies to help your legislators write better laws. I refer specifically to such studies as the Delaware Report showing that our elderly citizens are able to pay and are paying their doctor and hospital bills equally as well as those under 65. Facts as presented in this report will, in time, have their effect and will help to defeat those who oppose our free enterprise system. I could spend considerable time reciting your accomplishments — and, no doubt you would love it — but I believe it will be more useful to you and more helpful to the cause we represent if I let these few kind remarks convince you that I am a friend of the medical profession and, from here on out for the rest of the short time allotted to me, I intend to speak straight from the shoulder, harshly if necessary, to convince you that you doctors, as well as all of us who love America and the freedoms we enjoy, are not doing enough. The battle against the Communist world conspiracy which is threatening to engulf us is far from won and everyone of us must be a volunteer in the army of the free.

A strong America, morally, economically and militarily, is invincible. This is a fundamental fact, so clear that it seems ridiculous that I should even dwell upon it. Yet, what are we doing — are we strengthening this system of ours? Unfortunately, we are not. In fact, it seems we are doing everything we can to contribute to our own self-destruction. We need go back no further than the last session of Congress and the first few weeks of the present session, to learn how much we are succumbing to the socialistic pressures.

In the last session we amended the Unemployment Compensation Act to further invade the jurisdiction of the States and saddled American industry with an additional \$12 for every worker on the payroll. At the time, I, among others, warned that passage of the bill would be but a foot in the door for the social planners and the advocates of



Bruce Alger, Republican Member of Congress from the Fifth Congressional District of Texas was born in Dallas, June 12, 1918. He was graduated from Princeton University and served as a B-29 commander in the Pacific area during World War II. Congressman Alger was first elected to Congress in 1954 and has since been re-elected in 1956-58 and 60. He is a member of the powerful Ways and Means Committee of the House and his Dallas County District is among the largest (population) in the nation.

stronger Federal controls and that next we would be faced with a demand for Federal Standards in setting unemployment compensation. One of the main proposals of the Administration to be considered by this session of Congress in the next few weeks is the Administration bill for Federal Standards.

Last year we upped Federal contributions to the states for extending unemployment compensation by \$990 million. We passed the Area Redevelopment Act, we increased expenditures in the Public Housing Act, we expanded Federal participation in water pollution control, we opened the door for complete Federalization of our school systems by extending the National Defense Education Act and aid to schools in Federally-impacted areas. We liberalized the Social Security program, already actuarially unsound, and upped the taxes on both employees and employers.

Can anyone doubt that we are spending ourselves into bankruptcy with such irresponsible fiscal programs? These few items, picked at random, make up only a partial list of the domestic programs. We have not even considered, and I don't have time to go into the continuation of the inefficient, mismanaged, and oft-times corrupt foreign aid programs, which are bleeding the American taxpayers to the point where fiscal anemia may result in our demise as a free nation.

This session of Congress is not yet a month old and already, in his State of the Union message and in his budget message, the President has called for greater impetus to the spending program. He has submitted a \$115 billion budget which calls for greatly expanded welfare programs in every area of our lives.

At this moment, my own Committee on Ways and Means is wrestling with the Administration tax bill and when we are through, I warn you, it is going to cost you plenty.

The Federal Budget

In just a brief moment, because we could spend hours on the President's budget, let me point out some pertinent facts to you. The budget as presented is not a reliable guide-line, but it is a semblance of one. We should note in particular (1) The Cash Budget shows proposed spending of \$114.8 billion (not \$92.5 billion of the Administrative Budget), and estimated receipts of \$116.6 billion (not \$93 billion). (2) The estimated receipts must go up \$11 billion in the Administrative Budget, \$14 billion in the Cash Budget just to break even. That means the Gross National Product, total U. S. business income, must jump from the approximate \$520 billion level of 1961 to the forecasted \$570 billion or federal tax income will fall short and thus create a deficit. I

predict a deficit this year of several billions at least.

(3) Additional expenditures most assuredly will be asked by the President as the year progresses. (4) In our most prosperous year, no provision is being made to reduce our gigantic debt, on which interest cost alone will be over \$9 billion. No tax reform or cuts so badly needed, such as depreciation reform and reduction of each bracket, are planned. Indeed, the Korean war-time taxes are being asked for extension again. In addition to the postal rate increases which we passed on Wednesday of this week without even a roll-call vote, further tax increases may be expected.

The Physicians' Role

Now, doctors, what are we going to do about it? Applaud this speech, shake your heads wisely and tell each other what a rip-snorter I am? Assure me after this meeting that you are with me in my beliefs and tomorrow go back to your practice and forget all about it? I am sorry to report that in spite of your contributions as a group to which I referred at the beginning of this talk, too many of you as individuals are not doing enough to make yourselves heard in the halls of Congress. I applaud your motives. I cheer your good intentions, but I deplore your failure on too many occasions to stand up and fight for your convictions.

It may not be the polite thing for me to do to come here as your guest and to tell you that I think you are not doing your part as patriotic citizens in the struggle for survival in which we are now engaged. You may consider me to be impolite, a bad guest, but like dad used to say when he whaled the daylights out of us, I'm doing it for your own good. This is the bitter medicine I feel I must prescribe to cure the illness which is killing America, the complacency of our own people. I want to make you mad. I want to arouse you so that you will become effective exponents of the free enterprise system in which you and I believe. I want to move you to be as effective in directing the course of legislation as the labor unions and the bleeding-heart organizations who are willing to trade off this magnificent heritage we have for social philosophies which have failed in every country in which they have been tried and which can lead only to a lowered standard of living and poorer opportunities for our children and their children. There are two roles you can play. Both take some effort, a little bit of initiative, and a certain amount of courage. First, you can be more articulate in presenting your case to Congress on the measures which affect you. And by this, I don't mean just the bills which have a direct and sudden impact upon you personally or upon your particular field — medicine. Do you think labor comes before Congressional committees on

just those bills dealing with unions or with wages? Not on your life. Spokesmen for labor appear before Congressional committees on practically every piece of legislation on which we hold hearings. We are deluged with mail on every bill expanding the welfare state, increased Social Security benefits, housing, rural development, bigger farm programs. They are making themselves heard while too many doctors, because they are busy — and I know how busy you are — or because they don't want to take a chance on offending influential patients, stay out of politics, won't present a case before Congressional committees, seldom write their Congressman. You can do an effective job of directing legislation if, as individuals and through your societies you let Congress know how you feel on any bill that has an impact on the course of our Nation. This means letters to your Congressman and Senators. It means coming before Congressional Committees buttressed with facts and well-documented arguments. It means convincing all those with whom you have some influence of the rightness of our cause so they, too, will put pressure on their Representatives and Senators.

More important than every other action, however, is the part you can play in electing to office those who believe as you do. It does no good, my friends, to elect those to Congress who hold views con-

trary to your beliefs and then expect them to carry out your will. The way to protect this system of ours is to send to Washington a Congress which believes in it and will support it and will pass legislation to strengthen and expand it rather than contribute to its destruction. Believe me, it is important to you that you become active in politics from the precinct level on up.

It is not up to me to tell you which party to support, although you may have some rough idea of where I stand. I can only say that you should compare the philosophies which you must choose between, compare the voting records of Democrats and Republicans in Congress on such bills as medical aid and other socialist-like schemes, and then get behind the party which more nearly represents your own thinking.

Can you, as doctors, affect legislation? You bet your life you can, if you have the will to do it. I implore you to start today, from this very minute, become an active crusader for the American way of life. If you do not, and we fail to give control of the next Congress to those who share our thinking about the free enterprise system, I am very much afraid you may never have another chance to save the kind of America in which you and I believe and which is the only remaining hope of freedom on this earth.

Federal Building

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Berry, C. Markham	The Ellijay Clinic Ellijay, Ga.	Active	Blue Ridge
Cotts, Leonard L.	36 Butler Street, S.E. Atlanta 3, Ga.	DE 2	Fulton
Craig, James B.	Milledgeville State Hosp. Milledgeville, Ga.	Active	Baldwin
Gramling, Z. W.	Talmadge Mem. Hospital Augusta, Ga.	Active	Richmond
Jones, Lewis E.	VA Center Dublin, Ga.	Service	Laurens
Mir, Juan A.	Milledgeville State Hosp. Milledgeville, Ga.	Active	Baldwin
O'Shaughnessey, W. John, Jr.	724 Hemlock Street Macon, Ga.	Active	Bibb
Schley, Philip T.	Emory University Hosp. Atlanta 22, Ga.	DE 2	Fulton
Tipton, William R.	858 Clifton Court Circle Atlanta 6, Ga.	DE 2	Fulton
Tsao, Shu-yun T.	Athens General Hosp. Athens, Ga.	DE 2	Crawford W. Long

REFLEX ANURIA FOLLOWING RETROGRADE PYELOGRAPHY

Jay R. Johnson, M.D., and Rafe Banks, Jr., M.D., *Gainesville*

■ *Three illustrative cases are reported*

ANURIA IS A VERY UNCOMMON complication following retrograde pyelography. When it does occur, it is an extremely disturbing situation for the patient, his relatives and his physician. Our interest in this subject was stimulated after witnessing it on several occasions. A generous search through the literature would suggest its incidence to be very rare. Conversations with other urologists indicate it occurs far more frequently.

Anuria may be caused by a number of factors. A few of the more common ones are the "crush syndrome," poisoning due to ingestion of bichloride of mercury, carbon tetrachloride and intravascular hemolysis as seen in transfusion reactions. Swelling of the tubular epithelium may cause intrarenal pressure sufficient to overcome glomerular filtration.¹ Oliguria and anuria are seen in shock with systemic hypotension reducing the glomerular filtration pressure. There are reports by Adler² and Edwards³ of anuria secondary to psychogenic disorders. Hipsley⁴ collected nine cases of previously unsuspected ureteral calculi in children following ureteral catheterization. Ureteral obstruction may also be due to spasm or edema due to trauma. Considerable bullous edema may be present at the ureteral orifices. When it is possible to re-catheterize them, a hydronephrotic drip is seen with subsequent relief of symptoms. Lehrman⁵ has suggested that ureteral edema is the probable explanation for the majority of anuric cases associated with ureteral catheterization. He assumed that the edema represented "an exaggerated response to trauma" since skin tests of the catheter material and sterilizing solutions were not markedly positive. It is interesting to note that flank pain was a prominent symptom in each case relieved by re-catheterization.

Quinby⁶ states there is always some absorption of the contrast media into the blood stream during retrograde studies. The inference that tubular

changes result from this is opposed by Figdor⁷ who feels that a vascular shunt results from trauma during the examination. Wolf⁸ stated that extreme pain produced by ureteral obstruction reduces the renal blood flow causing anuria. He did not specify the exact mechanism.

The term "reflex anuria" is used to describe renal failure initiated by catheterization of the ureters and accompanied by no gross structural change in the ureters or kidneys.⁹ Using radiographic techniques in dogs, Trueta¹⁰ noted the absence of the opaque media in the kidney cortex if the sciatic nerve was stimulated. The medullary portion of the kidney became more pronounced. This was explained by a "vascular shunt" which diverted blood from the cortical area to the subcortical or juxta-medullary zone. Ischemia of the renal cortex and hyperemia of the medullary portion resulted. His work was reproduced by Tracey.¹¹ While Indigo Carmine was injected into the aorta of the rabbits, the renal pedicle of lower ureter was stimulated. The kidney cortex of the affected side became blanched while the opposite kidney revealed the characteristic bluish discoloration.

An extensive study by Moyer and Handley was carried out using renal clearance studies in dogs before and after sciatic nerve stimulation. They failed to demonstrate an arterio-venous shunt on this basis and concluded that no evidence was found to support Trusta's hypothesis.^{12, 13}

Technique

Certain aspects in this technique of retrograde pyelography have been incriminated as possible causes of anuria following this procedure. For this reason, the method in our cases is as follows:

1. Ether or Sodium Pentothal anesthesia provided relaxation and absence of painful stimuli.
2. A sterile field was carefully prepared.
3. Following urethral dilation, autoclaved catheters were advanced up each ureter. Particular effort was made to avoid trauma.

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REFLEX ANURIA / Continued

4. #4 Fr. catheters were used in children and #5 Fr. catheters were used in adults.
5. Overdistention of the renal pelvis was avoided by limiting the contrast media to two cubic centimeters in children and three cubic centimeters in adults.

Cases

The following four cases will be presented briefly and general observations made.

Case No. 1 Hall County Hospital #15,308. This 65 year old white male was investigated because of recurrent urinary tract infection. His general physical condition was within normal limits. Laboratory studies revealed numerous white blood cells on urinalysis and a serum non protein nitrogen value of 39 mgs per cent. Endoscopy showed typical findings of cystitis but was otherwise unremarkable. Following negative bilateral retrograde pyelography anuria was immediate and persisted for 86 hours. His sensorium remained clear and he was afebrile. At no time did he complain of flank pain or flank tenderness. His non protein nitrogen rose to 60 mgs. per cent. He received chemotherapy during this time and limited fluids by mouth as he complained of only slight nausea and did not vomit. Diuresis began spontaneously and the results of the above test returned to normal prior to his dismissal from the hospital.

Case No. 2 Hall County Hospital #48,051. This eight year old white female was admitted with a history of gross and microscopic "painless" hematuria of one month duration. Her physical examination was not remarkable except for a mild vaginitis. Urinalysis revealed a few red blood cells and a trace of albumin. A hemogram was normal. Cystoscopy showed mild inflammation of the bladder wall. Bilateral retrograde pyelograms were obtained without difficulty and were normal. She was anuric for 70 hours, thereafter. Strict fluid limitation and antibiotics were given parenterally because of recurring vomiting. Non protein nitrogen determinations gradu-

ally rose to 75 mgs. per cent while her serum potassium reached 6.3 mgs. per cent. A plain x-ray of her abdomen failed to show any change in kidney outline and she denied flank tenderness. Following her spontaneous onset of diuresis, her blood chemistry determinations returned to normal. She was afebrile throughout her hospitalization.

Case No. 3 Hall County Hospital #49,507. This six year old white female was treated for cystitis elsewhere one month prior to her admission. Her symptoms of frequency, urgency and pain upon urination responded to sulfonamide therapy. One week prior to admission, she had gross, painless hematuria which cleared prior to examination by one of us. Her physical condition and laboratory studies were excellent except for microscopic hematuria. Endoscopy revealed a rather small vesical neck and trigonitis. Retrograde pyelograms were easily performed and were normal. Thereafter, she became anuric and remained so for 48 hours. Nausea and vomiting was present for most of this period. She denied flank pain and remained afebrile. Supportive therapy, fluid limitation and antibiotic therapy was provided. Her non protein nitrogen was 74 mgs. per cent and serum potassium reached 5.3 mgs. per cent on the second day prior to the onset of diuresis. These values returned to normal before she was dismissed.

Case No. 4 Hall County Hospital #50,919. This 63 year old male was investigated because of gross hematuria occurring nine months following prostatic resection. His general physical condition was within normal limits. Aside from red blood cells in his urine, the laboratory findings were not remarkable. Endoscopy showed bleeding from his prostatic fossa. Bilateral retrograde pyelography was performed to rule out renal lesions. His subsequent anuria was immediate and lasted for 124 hours. He was nauseated and vomited occasionally but this was not a problem. His sensorium became moderately clouded but his temperature did not rise significantly. No flank tenderness was elicited. A plain film of his ad-

domen showed the kidney sizes to be unchanged. General measures for limiting fluids and protein intake were taken. The most elevated non protein nitrogen value was 85 mgs. per cent while the potassium was 6.1 mgs. per cent. Diuresis occurred spontaneously and he was dismissed from the hospital with normal electrolyte levels.

None of the above patients were found to be hypotensive. Urethral catheters were left indwelling to measure any urine reaching the bladder. These were observed frequently.

Follow up studies were obtained on two patients (case #2 and case #1). They each denied any urinary complaints. Their physical examinations were normal. Early morning voided specimens revealed a specific gravity of 1.022 and 1.020. Urinalysis obtained at the time of their return was negative for albumin and cellular elements. Both had normal non protein nitrogen values. Excretory pyelograms were considered normal.

Discussion

Anuria complicating a diagnostic procedure such as ureteral catheterization, places a tempting decision before the urologist. Should he intervene in some manner or should he simply provide the patient with supportive measures and observe him. Instrumentation and recatheterization of ureters was not attempted in our cases. We felt it was not warranted in the absence of fever, flank pain or tenderness. Also, x-rays did not suggest an increase in kidney size. Experience has shown that this type of patient eventually diuresed spontaneously. Epidural anesthesia was also considered. Tomlin¹⁴ and Moore¹⁵ demonstrated its effectiveness in two cases. Diuresis followed its application in each. One patient received continuous spinal anesthesia on three separate occasions. It is interesting to note anuria promptly returned as the block was removed twice. He eventually was able to make urine spontaneously. The fact that the block was effective, if only temporarily,

would lend support to the "reflex" etiology of their cases. Spinal anesthesia was not used in our group of patients because their clinical condition did not warrant it.

Summary

Anuria following instrumentation of the ureters is probably more common than the literature would indicate. Four cases are briefly presented. In the absence of symptoms and signs suggesting hydronephrosis or pyonephrosis, only supportive measures were provided these patients. Our experience suggests that "reflex anuria" is a feasible explanation for certain cases of anuria following retrograde pyelography.

290 Enota Drive

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THE RESPONSIBILITY OF THE DRUG INDUSTRY

The activities of the universities and their research laboratories and those of the pharmaceutical industry are not competitive but complementary. There is an increasingly broad overlapping of interests. Both do and should have large and effective research programs. It is the prime function of the one to probe and to teach, and it is in our American system the function

of the other to do research with the aim of finding and developing new health-giving aids which will come slowly or not at all if we place our dependence upon the government, or for that matter on universities, either state or private.

Lowell T. Coggeshall, M.D.,
Vice President University of Chicago

PRECANCEROUS DERMATOSES

Ray O. Noojin, M.D., *Birmingham, Alabama*

■ **Eventually 20 per cent or more of these lesions will invade the dermis as squamous or basal cell cancer.**

THE FREQUENCY OF SKIN cancer as well as its ominous significance warrant increasing emphasis. There are in addition those lesions of the skin which often eventuate in skin cancer and these, too, merit adequate recognition. All physicians should be aware of the clinical appearance of these malignant and premalignant groups and should see that appropriate treatment is carried out.

It is the purpose of this paper to discuss the recognition, course, causal factors and management of the group known as the precancerous or premalignant dermatoses. These include:

- (1) Senile keratoses and cutaneous horn
- (2) Keratoses resulting from
 - (A) Ingestion of arsenic
 - (B) Exposure to tar
- (3) Radiodermatitis
- (4) Leukoplakia
- (5) Xeroderma pigmentosum
- (6) Melanotic freckle
- (7) Bowen's disease
- (8) Erythroplasia (Queyrat)

All of this group, except the melanotic freckle, may be considered as intraepidermal carcinoma or squamous cell carcinoma in situ and signifies the presence of malignant changes within the prickle cell layer. These lesions will remain clinically benign for years, but eventually 20 per cent or more will invade the dermis as squamous or basal cell cancer. Once squamous cell cancer develops and invasion of the dermis occurs, unless the lesion is adequately destroyed, further spread, metastasis and subsequent death may follow.

Predisposing Factors

The following factors may play a significant part in the patient's proclivity toward developing premalignant and malignant changes in the skin.

(1) *Heredity.* Certain hereditary factors may predispose. Xeroderma pigmentosum, an inherited abnormality, is a serious disease, and frequently these patients die from skin cancer before reaching puberty.

(2) *Ingestion.* Inorganic arsenic if taken internally in sufficient quantities may lead to malignant cutaneous changes.

(3) *Customs.* Excessive smoking and the prolonged use of chewing tobacco or snuff may lead to leukoplakia.

(4) *Trauma.* Persistent irritation from physical or infectious agents may lead to skin cancer.

(5) *Occupation.* Exposure to sun (farmers, sailors, etc.) and tar (asphalt worker) often leads to the development of premalignant keratoses.

(6) *Race.* Heavily pigmented individuals as the Negro seldom develop skin cancer. Those with blonde or rufous complexions are considerably more susceptible to the development of premalignant lesions over exposed areas.

(7) *Age.* The older the individual the more likely his skin is to become cancerous.

(8) *Sunlight.* Overexposure to sunlight is perhaps the *most common* predisposing factor to skin cancer.

Senile Keratoses

Those who are more apt to develop senile or actinic keratoses are those who are exposed to the sun more often. Males develop skin cancer twice as often as do females, and this is probably influenced by the fact that they generally are subjected to greater sun exposure.

To substantiate further the effect of sunlight, it is known that skin cancer occurs relatively more often on the forehead in women than in men because of the more adequate protection of the male hat. Occurrence is less often on the female ear because of the greater protection by their hair. It occurs less

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often in both sexes on the submental triangle because of diminished sun exposure in that area. Dust and smoke tend to shut out the carcinogenic rays of the sun, but this is not true of fog and clouds.

Senile or actinic keratoses occur most often on the exposed areas of elderly individuals or on those with a skin of old age type and predominate on the face, ears and dorsa of the hands (Figure 1). The

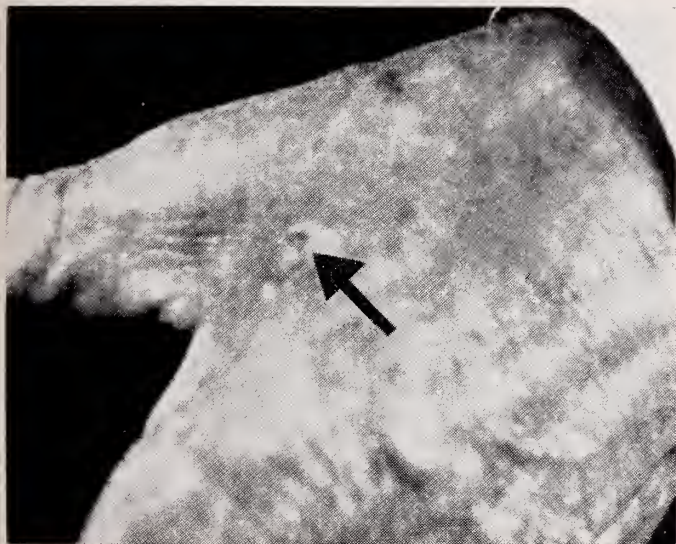


Figure 1. Senile or actinic keratosis on the hand of an elderly farmer. Note the wrinkled, atrophic skin. The arrow points to a senile keratosis.

skin of these patients is usually thin, atrophic and dry over the exposed areas. The lesions tend to have an erythematous base, are papular or flat, slightly atrophic, infiltrated and are covered with an adherent keratin scale, and vary from a few millimeters to several centimeters in size. Removal of the scale usually results in a bleeding, moist surface. They tend to be elevated on the lips and dorsa of the hands and in other areas may be relatively less conspicuous. They are rare in those with increased pigment as the Negro and Indian. Frequently senile keratoses lead to the development of a cutaneous horn, which appears as a hard, elongated cornified projection (Figure 2). These lesions should in most instances be excised and submitted for histologic study, since the underlying cutaneous changes may already reveal squamous cell carcinoma. Rapid growth, ulceration or inflammatory reaction may signify malignant change.

Where practicable, a biopsy should be done since the most astute clinician can never be certain by clinical appearance alone that the lesion is a senile keratosis and that malignant change may not already have occurred. Acceptable treatment procedures include: (1) electrodesiccation, (2) surgical excision, (3a) daily application of 20 per cent podophyllin in compound tincture of benzoin, (b) cover with dry gauze (This is particularly helpful for those who have unusually large lesions and where more com-



Figure 2. Cutaneous horn.

plete destruction would be impractical.), (4) application of liquid nitrogen, and (5) dermabrasion. X-ray therapy is usually contraindicated in the treatment of these lesions.

Sun, soap and other drying agents should be avoided. Involved areas should be kept well greased with cold cream or Nivea Skin Oil. The local use of sun screen creams (A-Fil, Neo A-Fil) is helpful when sun exposure is unavoidable. Recent reports indicate that the daily administration of 100,000-200,000 units of aqueous vitamin A may be helpful. Those patients who tend to develop numerous lesions should be checked at three to six month intervals for removal of all suspicious areas. The ingestion of methoxsalen (Oxsoralen, Meloxine) may increase sun tolerance under certain specific conditions by increasing the thickness of the stratum corneum.

Keratoses Produced by Ingestion of Arsenic or by Exposure to Tar

Inorganic arsenic is a carcinogenic substance, and its use in patients (Fowler's solution, Asiatic pills) for sustained periods may result in hyperkeratoses on the palms and soles. Prolonged exposure to arsenic in sprays or insecticides may also lead to the development of arsenical keratoses. Less frequently the trunk, face and mucous membranes may be involved. Prolonged administration may lead to thickened nails and loss of hair. Hyperpigmentation (arsenical melanoses) may follow exposure to sun. The lesions are yellowish to brown, rough-surfaced and elevated. They may resemble senile keratoses, and at times even Bowen's disease. Eventually the lesion may develop into squamous cell carcinoma.

Ingestion of inorganic arsenic should be avoided. If the drug must be given, make certain the prescription is marked "non-refill."

Over-exposure to tars and oils may lead to the development of premalignant and keratotic lesions.

PRECANCEROUS DERMATOSES / Noojin

Examples of this were seen many years ago in chimney sweeps, who developed scrotal cancer and more recently in those working with asphalt and other similar products. Excessive exposure to products of this type should be avoided.

Most of these lesions deserve a biopsy and adequate removal either by electrodesiccation or surgery.

X-Ray and Radium Keratoses

Chronic radiodermatitis presents a characteristic picture and follows over-exposure to x-rays or radium. Sometimes it is produced of necessity in treating cancer already present; oftentimes it results through error (overdosage, carelessness, repeated fluoroscopic examination, inaccurate records, etc.) If the patient's skin tolerance for x-ray therapy is exceeded, the area treated eventually becomes dry, atrophic, areas of hyperpigmentation and depigmentation develop, dilated capillaries and keratoses appear, permanent alopecia occurs, and eventually ulceration tends to develop. (Figure 3) If these areas are neglected, malignant degeneration may occur.



Figure 3. An area of radiodermatitis. Telangiectasis, atrophy, pigmentation and early ulceration (arrow) are present.

Beware of overtreating a patient with x-ray or radium. If you are using ionizing radiation as a physician or dentist, protect yourself adequately.

Once chronic radiodermatitis has appeared the abnormal changes that develop are relatively irreversible. Biopsy followed by surgical excision, and if necessary replacement with a skin graft is often the treatment of choice. This is particularly true if ulceration or tumor growth is obvious. If surgical excision must be delayed the local area may be treated with Aloe Vera ointment, Hollandex ointment, or one per cent hydrocortisone ointment. These areas should be protected from sun exposure.

Leukoplakia

Leukoplakia may be described as a whitish or silvery, leathery thickening of the mucous membrane. (Figure 4) Most often it is found at the sites of



Figure 4. Leukoplakia involving the left buccal mucosa and the tongue.

chronic irritation or as a complication of previous lesions. Attempts to remove these whitish plaques forcibly usually results in bleeding. Leukoplakia is more prevalent in males over 40. The more common sites are the lips, gums, buccal mucosa, dorsum of the tongue, and genitalia.

The etiology of leukoplakia is unknown, but the following appear to be predisposing factors: tobacco (smoking, chewing, snuff), syphilis, projecting dentures, faulty occlusion, projecting teeth or dental caries, avitaminosis. Prolonged irritation from the use of tobacco is probably the most significant predisposing factor.

Vulvar lesions more often occur in the post-menopausal period, whereas involvement of the glands penis is seen rarely and usually only in elderly men.

Leukoplakia must be differentiated from lichen planus, secondary syphilis (mucous patch), moniliasis, lupus erythematosus, and lichen sclerosus et atrophicus. A biopsy may be necessary to establish a correct diagnosis. An erroneous diagnosis of leukoplakia instead of lichen sclerosus et atrophicus has frequently resulted in unnecessary vulvectomy.

Prophylactic measures for oral lesions may cause regression. Tobacco should be discontinued in all forms. Dental examination is indicated when oral lesions are present and points of dental irritation should be corrected. The dissolving of buccal vitamin A tablets (75,000 to 150,000 units)* in the mouth may be helpful. Equal parts of Elixir Benadryl and water as a mouth rinse three times daily after meals

*Vi-Dome-A Buccal Tablets (Dome)

has been recommended. If the lips are involved, sun exposure should be avoided as well as irritating biting habits. Avoid strong tooth paste and mouth rinses.

In advanced lesions additional measures should include: (1) a biopsy, if the lesions are ulcerated, fissured, or markedly thickened, and (2) destruction of the lesions by (a) curettage followed by the local application of trichloroacetic acid, (b) electrodesiccation, or (c) surgical excision. Advanced carcinoma of the mouth carries a poor prognosis.

Xeroderma Pigmentosum

This is a rare congenital disease which tends to be manifested as early as age two or three. Within the first few years of life the exposed skin becomes reddened and freckled. Photophobia may be noted early. Later the involved areas become dry, scaly, atrophic, and telangiectatic. Keratoses and verrucous growths soon occur over the exposed areas when sun exposure is inevitable. All keratoses should be removed by electrodesiccation or by total excision as rapidly as they develop. An occasional patient may be temporarily benefited by the daily ingestion of methoxsalen as suggested in the section on senile keratoses.

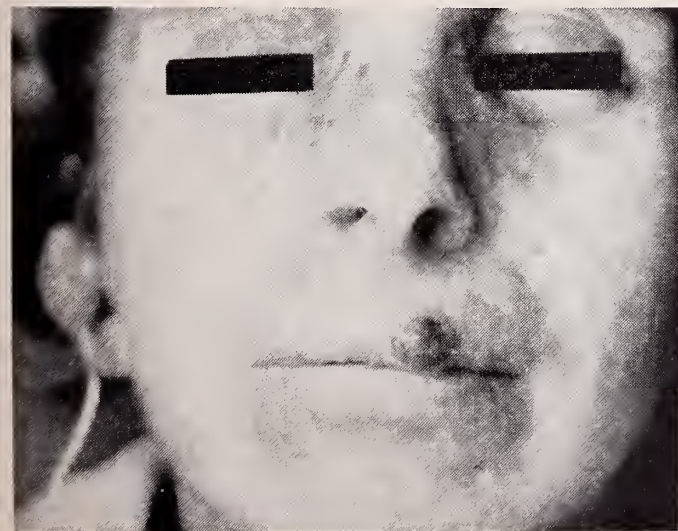


Figure 5. Xeroderma pigmentosum. Note early squamous cell epithelioma involving the upper lip.

Melanotic Freckle of Hutchinson (Lentigo maligna)

This uncommon lesion tends to occur after puberty and at an average age of 40. It first begins as a brownish freckle and enlarges contiguously in an uneven fashion. As it enlarges the pigmentation is spotty and in fact patches of depigmentation may be present within the lesion. The macular or early stage is characterized by an irregular outline, uneven color, changeability and lack of induration. The

most common site is the face, although the lesion may occur upon any area and has even been noted on the conjunctiva.

When malignant change develops it is usually marked by the presence of an elevated verrucous-like nodule or tumor which bleeds easily. Approximately one-third of melanotic freckles develop into melanocarcinomas.

Metastases develop slowly and do not tend to be as rapidly fatal as those developing from malignant melanoma (malignant nevus-cell nevus).

The treatment of choice is to remove the lesion surgically as early as is feasible. Radical surgery is usually not necessary. If the lesion is recognized before malignant change has occurred it should be biopsied and removed either by the scalpel or electro-surgery.

Bowen's Disease

This develops slowly as a single lesion or less commonly as multiple sharply margined superficial plaques. These are dark red to brown, may be covered with scales or a thin crust, and may ulcerate. (Figure 6) The surrounding skin is usually



Figure 6. Arrow points to an eczematoid plaque of Bowen's disease.

reddened. Often the lesions may have produced local atrophy. They are seen most commonly on the trunk.

Although considered among the precancerous dermatoses, the lesion is actually a form of intra-epidermal squamous cell epithelioma. Eventually the lesion may invade the cutis as a squamous cell cancer. Histologically the changes seen are similar to those seen in the other precancerous dermatoses.

Treatment should consist of a *biopsy*, followed by removal of the lesion by surgical excision, electrodesiccation or x-ray therapy.



Figure 7. Erythroplasia (Queyrat) involving glans penis.

This is an uncommon precancerosis which may occur over the male and female genitalia. The slowly enlarging lesions are sharply margined and possess a moist, brilliant red, velvety surface. (Figure 7) They occur most often on the glans penis of those who have not been circumcised. This is considered by some as an early moist stage of Bowen's disease and by others as a form of leukoplakia. If untreated, the eventual development of squamous cell carcinoma may occur.

When the diagnosis is definitely established, the lesion should be thoroughly destroyed by surgical excision or electrodesiccation.

Medical College of Alabama

THE CIVIL DEFENSE EMERGENCY HOSPITAL

WHAT IS IT?

The Civil Defense Emergency Hospital (CDEH) is a civilian adaptation of the Mobile Army Surgical Hospital (MASH) unit which proved so effective in the Korean conflict. It is an austere, but completely functional 200-bed general hospital designed to be set up within an existing structure, such as a school or church building, or community center, which has been pre-selected by competent local authorities.

To set up the CDEH requires a floor area of 15,000 square feet which will permit separation of wards, operating rooms and other functional sections; and a suggested staffing complement of 18 physicians, three administrators, 33 nurses, five anesthetists, two pharmacists, and 118 trained aides to be drawn from local resources.

The CDEH is organized to function independently, or in conjunction with existing hospitals.

WHY HAVE IT?

The primary mission of the CDEH is to become the core of the post-attack hospital system essential to provide medical care for the surviving population. It is estimated that up to 80 per cent of the 1,500,000 hospital beds available in the United States today would be destroyed or unusable as a result of a mass attack. The prepositioned CDEH's can be expected to provide approximately half of the beds required following such a catastrophe.

HOW MANY ARE THERE?

As of July 1, 1961, the Federal Government had purchased 1,930 CDEH's at a cost ranging from \$21,000 to \$26,000. Almost all of this number have been prepositioned throughout the United States.

Plans are underway to procure, assemble and distribute 750 more hospitals with a 30-day backup sup-

ply. In addition, it is planned to expand the three to four-day backup supply of the present 1,930 hospitals to 30 days.

WHAT DOES IT INCLUDE?

The CDEH contains provisions for the following departments: laboratory; pharmacy; X-ray; surgery, including multiple operating suites; shock, treatment and holding wards; reception or sorting area; and medical and surgical supplies sufficient for expedient operation.

Auxiliary equipment included is a limited supply of medical and administrative records; a 15 KW generator to provide auxiliary power if local electrical supply is disrupted; and a 1,500 gallon water tank and pumping unit for emergency water supply.

HOW IS IT STORED?

The present hospital weighs 23,200 lbs. and requires 1,577 cu. ft. of storage space. There are 295 different items of supply and equipment, which are packed in some 350 crates to facilitate transportation, handling and long-term storage.

CDEH's are assigned by Federal-State agreements, based on carefully developed criteria which include such factors as strategic, but non-target locations, adequacy of storage facility and responsible custodianship.

WHAT IS INVOLVED IN ITS SETUP?

It is possible to erect the entire hospital with 120 man-hours of labor. Speed in setting up the hospital, however, is not a criterion of its usefulness, but rather an indication of its simplicity and design.

Every community with a prepositioned hospital is urged to arrange for responsible personnel to obtain training in the setting up and operation of the CDEH. CDEH's designed for training are available from the States.

FLUID AND ELECTROLYTE BALANCE

Neil G. Perkinson, M.D., *Atlanta*

- *In caring for the aged or seriously ill patient, intelligent regulation of fluid and electrolyte balance is frequently lifesaving.*

THE ENORMOUS GROWTH in knowledge of the physiology of water and electrolyte balance in man over the past two decades has had an accompanying increase in the body of clinically useful information such that a thorough and practicable knowledge of these physiologic principles is an absolute necessity for the intelligent management of the patient in almost any of the present-day fields of medicine. The purpose of this necessarily brief paper is to present an approach to the problem of the management of fluid and electrolyte balance in these various patients in the light of these recent developments of knowledge.

Absolutely no originality is claimed for this presentation; many of the basic concepts were expounded by Claude Bernard almost a century ago, and most of the following represent the ideas and work of many distinguished investigators in the fields of medicine, biochemistry and physiology, but the particular approach and much of the material presented here represents work done in the Surgical Metabolic Unit of the Department of Surgery, Columbia University and Presbyterian Hospital, the Surgical Physiology of Memorial Center for Cancer and Allied Diseases, and the Renal Research Team of New York University, and particularly by Drs. Kathleen Roberts, Henry T. Randall, and William Pitts.

Normal Values

Accepting the findings that the human body weight is made up of about 60 per cent water, we find also that this water (with its contained electrolytes) is divided into two distinct compartments: (1) that water inside the cell membrane, or intracellular water, and (2) that water outside the cell membrane, the extracellular water. The latter is further sub-

divided into (1) intravascular water—that water within the lumina of the blood and lymph vessels—and (2) the extravascular extracellular water—that water contained within the interstitial space. Intracellular fluid makes up about 40 per cent body weight; interstitial, 15 per cent; and intravascular, five per cent (plasma).

Electrolytes are present dissolved and ionized in body water, and by far the most easily analyzed of the body fluid compartments is the plasma because of its availability for biopsy by venipuncture. For completeness sake, Table 1 is compiled to show the

TABLE 1

Electrolyte (mEq/l)	Plasma (5% body wt.)	Interstitial (15% body wt.)	Intracellular (42% body wt.)
ANIONS:			
Bicarbonate	27	36	10
Chloride	103	103	0
Protein	25	2	81
Sulfate	1.2	1.2	22
Phosphate	2	2	89
Organic Acid	trace	7	0
CATIONS:			
Sodium	143	141	4
Potassium	4.5	4.5	154
Calcium	5.3	5	0
Magnesium	2.1	2	44

average values of the important electrolytes as found in the various fluid compartments of the normal human being.

It should be obvious from this table that interstitial fluid and plasma (together making up the total extracellular fluid) have almost identical constituents with the exception of protein whose concentration as an anion in plasma is many times the concentration in interstitial fluid. The most striking differences in concentration of electrolytes in the normal person

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are thus found between intracellular fluid and extracellular fluid. The major extracellular cation is sodium, with small amounts of potassium, magnesium and calcium; the major intracellular cations are however, potassium and magnesium with scant quantities of sodium. The major extracellular anions are seen to be chloride and bicarbonate (and in plasma, as above, protein); the major intracellular anions are phosphate, sulfate, and protein with a small amount of bicarbonate and virtually no chloride.

Before undertaking major surgery it is often wise to determine what the particular patient's normal electrolyte values are because of the extent of the range of some of the normal values. It is our experience that in the case of serum sodium, the range of normal is not higher than 145 mEq/l. A thorough understanding of normal averages and ranges is essential to evaluate properly, changes in the patient's status pre- or post-operatively, and figures in this table, particularly those of sodium, potassium, bicarbonate (carbon dioxide combining power), and chloride should be a part of working knowledge of every physician and surgeon alike.

Interplay of Factors

The term "balance" implies an equilibrium among two or more different things. Maintaining fluid and electrolyte balance requires an understanding of the normal daily intake and output of water and of the major electrolytes required for body economy. In addition, abnormal losses and their electrolyte content, and deficiencies acquired before treatment begins must be considered. The problem may be divided into three parts. The first of these, baseline, answers the question, "What do I have to give the patient if he is wholly or partially deprived of oral intake, but is otherwise normal or relatively normal condition?" The second, dynamic loss, answers the question, "What losses does the patient have as the result of his disease, operative procedure or both that are abnormal and that are going on under observation, and what is required to replace these losses?" The third category, static debt, answers the question "What deficiencies or excesses does the patient have in water, electrolytes and blood volume at the time when I begin to treat him?"

The total daily intake of water and electrolytes required will be the sum of the baseline requirements, plus the dynamic loss plus a proportion of the deficiencies in water, electrolytes and blood volume. A daily or more frequent evaluation of the status of the baseline and dynamic loss and a critical evaluation of deficiencies at the beginning of therapy enable the physician to evaluate the problems of main-

taining a normal or nearly normal intra- and extracellular fluid structure for the patient before, during, and after a traumatic experience.

Baseline

In considering baseline requirements for patients on parenteral fluids it is perhaps best to approach the problem from an analysis of the types of losses which normally occur each day, and, by adding these normal losses together, to approximate the amount and type of fluids which are required to maintain balance. These losses consist of urine, the loss which occurs as the result of the evaporation of water from respiratory epithelium in the process of breathing, and loss by direct evaporation of water from the surface of the skin.

Frank sweating, as such, is not a consideration in baseline losses in the normal individual. In general, and particularly in the postoperative period, the surgeon likes to see a urinary volume in excess of 1000 cc. in each 24 hour period. Under ideal circumstances, according to Gamble, the kidneys are capable of excreting a urine whose concentration of solutes is 1.4 osmoles/l or approximately four times the normal plasma concentration. However, in the postoperative period renal function cannot be assumed to be of normal or maximal efficiency, and furthermore, most patients who have to undergo major surgical procedures are sufficiently advanced in years so that their renal function is diminished by a process of attrition involving arteriosclerosis and reduction of functional nephrons. While with maximum concentration, all of the necessary products of metabolism per day could be excreted in between 400 cc. and 500 cc. of urine, it is better to provide for a liter to 1200 cc. per 24 hours in the 70 kilogram adult.

In addition, allocation must be made for respiratory evaporation loss and for loss by evaporation from the surface of the skin. Confirmed observations have shown that an intake of 800-1000 cc. per day is necessary to provide for these insensible losses.

Another source of water in the semi-starving patient is preformed water present in tissues destroyed to provide calories, and water of oxidation formed by the combustion of these tissues and of administered calories. Water of oxidation averages 12 cc. per 100 calories burned or 200-300 cc. per day, and additional preformed water loss of approximately the same amount occurs when minimal carbohydrate is provided. Thus, in effect, about 400 cc. of water is added to the intake and output, and is reflected by weight loss. However, this is not infrequently ignored because there is a variable loss of water normally in stools.

A summary of the baseline requirements of the normal adult might be as follows:

- (1) Water:

For urine output

For respiratory loss

For skin loss

Total

1200 cc.

450 cc.

350 cc.

2000 cc. in 24 hours
- (2) Electrolytes:

Sodium (as NaCl):

Potassium:

Chloride:

100 mEq (6 Gms) per day

80 mEq per day

120 mEq per day
- (3) Calories:

100 grams glucose per day minimum; increasing the quantity above this 100 grams does not significantly increase the amount of nitrogen spared and may add to the patient's problems by enhancing dehydration due to osmotic diuresis of the excess as well as helping produce hypokalemia.
- (4) Vitamins:

Ascorbic acid is poorly stored, rapidly depleted, and needs to be replaced. Other vitamins are not necessary unless the patient is malnourished.

The basic requirements are altered due to various processes. Essentially, the items which increase the requirements are those in which there is an increased rate of metabolism, namely (1) size (large), (2) youth, (3) increased BMR, (4) fever, (5) high atmospheric temperature and/or humidity. The factors which decrease these requirements are: size (small, except infants), old age, decreased BMR, cardiac failure and renal failure.

Dynamic Loss

The second major category of fluid balance is dynamic loss. This includes both external abnormal losses of water and electrolytes, and those temporary functional losses which result from a shift of fluids within the body. These processes take place during treatment, are measured in drainage bottles or reflected in the patient's changing status, as contrasted with pre-existing deficiencies which are separately considered. These are losses of water and electrolytes by abnormal routes or in abnormal amounts, sometimes referred to as "extra-renal losses."

As seen in Table 2, realizing that in the normal state, these organs secrete 8000-10,000 cc. fluid each 24 hours and that in some pathologic states

this volume may be even greater, one is able to appreciate the enormous losses to the body in water and electrolytes which are possible in removal by suction intubation, vomiting, diarrhea, fistulas, open wounds, burns, etc.

Not only does gastrointestinal fluid represent a loss in water which may be replaced volume for volume, but also a loss in electrolytes. Early observations indicated that gastrointestinal tract secretions were approximately isotonic and gave rise to the idea that the logical replacement of them was isotonic sodium chloride. This serves well enough if renal function is good and the kidneys can discriminate among the ions necessary for replacement and excrete hypertonic urine. Unfortunately in the critically ill patient both before and after operation, this renal selectivity is often much impaired, and as a result a more quantitative replacement of gastrointestinal tract drainage is necessary. Analysis of drainage from the gastrointestinal tracts of surgical patients have demonstrated (Table 2) that the average drainage is not isotonic but is hypotonic insofar as sodium and chloride are concerned. A marked difference in type of electrolytes lost, depending upon the location of the drainage point within the gastrointestinal tract, is found.

Replacement Procedures

An understanding of the different types of electrolyte losses from the gastrointestinal tract is essential to their adequate replacement. It is not necessary to quantitate replacement when drainage from the gastrointestinal tract is small, in the order of 500 cc. to perhaps 1000 cc. per day, and of short duration, no more than one or two days. It is usually sufficient, as has been the general clinical experience, simply to provide an equivalent volume of isotonic sodium chloride. However, in patients who are seriously ill and in those in whom gastrointestinal tract drainages are large in volume or persist over many days, a more quantitative replacement is necessary. The result of large volumes of sodium chloride in replacement of drainage from a fresh ileostomy, for example, is likely to be a chloride acidosis as the result of the excessive loss of sodium as compared to chloride. On the other hand, the use of sodium chloride solution in isotonic form to replace a 1/3rd isotonic gastric juice draining from a patient with an achlorhydria is sufficient to provide for the storage of large volumes of sodium chloride and a consequent over-expansion of the extracellular fluid space.

If laboratory facilities are available and the quantities of gastrointestinal tract drainages are large, analysis of their content and quantitative replacement is in order. If not, then a practical guide to the replacement of these losses is illustrated in Table 3,

TABLE 2

Average gastrointestinal tract losses, mEq per liter.

	Sodium	Potassium	Chloride
Gastric	59	9.3	89
Small bowel	105	5.1	99
Ileum	117	5.0	106
Ileostomy, recent	130	16.2	109
Cecostomy	79	20.6	48
Bile	145	5.2	100
Pancreatic juice	141	4.6	77

TABLE 3

Proportions of parenteral fluids for semiquantitative replacement of gastrointestinal fluid losses.

	Dextrose in water	Dextrose in saline	M/6 Sodium lactate	0.75% ammonium chloride
Gastric, Average	33%	67%		
ulcer	20%	30%		50%
low acid	67%	33%		
Small intestine	20%	70%	10%	
Ileostomy	10%	75%	15%	
Bile		67%	33%	
Pancreas		50%	50%	

Above solutions in volume for volume replacement of losses; potassium chloride 10 mEq per liter to be added.

which gives a "rule of thumb" for the replacement of gastrointestinal volumes according to their nearest round figure equivalents in four replacement fluids.

In addition, there are other losses which may occur, some of which are rather obvious, and some of which are less so. Among these are the surface losses from wounds, those losses due to excessive sweating and those due to hemorrhage.

Of the surface losses from wounds we may include areas of traumatic excoriation along with a most important group, that of thermal burns. The material which is lost from the surface of wounds is similar to plasma in its composition, and replacements are water, volume for volume, and a plasma concentration of electrolytes. Hartman's solution is ideal for this loss; in addition, it may be necessary if there is an extensive loss of plasma protein to replace this protein intravascularly.

Sweat Loss

Sweat loss is exceedingly variable both in amount and electrolyte concentration; is best estimated, as indeed is overall water balance, by daily or more frequently weighing the patient; and should in general be replaced parenterally with 1/3rd to 1/2 volume of 0.9 per cent NaCl and the remainder as nonelectrolyte-containing fluid either parenterally or orally.

The last of these external losses to be considered is probably the most vital—that of hemorrhage. As important as hemorrhage is to life, detailing of this problem need be no more than simply to insist upon volume for volume replacement of the loss.

The second great group of dynamic losses which must be considered is that of internal fluid shifts or the so-called "third space effect" with the intracellular space and the extracellular space being the first two fluid spaces. This is best understood if we recall the chain of events set in action which has been described by Selye under the general classification of the alarm reaction. Those which seem most pertinent are: intracompartamental fluid shifts, transi-

tory water retention accompanied by a longer retention of sodium and chloride ions, and a marked excess loss of potassium and nitrogen with potassium lost in excess of its intracellular ratio to nitrogen. The increase of the extracellular fluid space is initiated at the time of injury, appears to reach its zenith about the second or third post-injury day, and begins to resolve by the third or fourth day in relatively minor trauma and may persist for a week or more following major procedures, particularly if there are postoperative complications.

The above reaction to injury is considered to be a general one—there is temporary fluid and sodium retention over the entire body. Of probably more particular importance to us in the postoperative management is that of the localized accumulations of fluid—the "third space effect." The most obvious of these third spaces is seen in thermal burns; others are in cavity collections as peritoneal and pleural infection or effusion. In the gastrointestinal tract we have pooling as in paralytic ileus and obstruction; and in all wounds there are edema, hemorrhage and serious fluid pools.

Thus, water and electrolytes may be effectively lost to the circulation and extracellular fluid space without actually leaving the body itself. Fluid accumulated within the body, yet unavailable to it, amounts to the creation of a third space. This third space, be it the result of burn, trauma or infection, depletes both the extracellular and the intracellular compartments to satisfy the demands for its own creation. Since the composition of third space fluid is essentially that of extracellular fluid, and since it results in internal dehydration, the replacement which is required is in terms of the composition of extracellular fluid and frequently, if protein loss is high, of plasma. At the end of 48 or 72 hours in the case of the burn and in a variable period, usually longer in the case of infections and crush injury, the third space begins to resolve. When this occurs replacement of electrolytes and water must be stopped, for the patient obtains an auto-infusion of water and extracellular electrolytes from the resolving third space. The patient may have some difficulty in disposing of what has now become an over-expanded total extracellular fluid space. Intake at this point must be reverted back to baseline, and electrolyte intake must be curtailed while the patient undergoes a diuresis to dispose of the fluid returning from the third space.

Static Debt

The last category which we must consider is that deficiency or excess in body water, in intracellular and extracellular electrolytes, and in blood volume

which the patient demonstrates when we first see him and begin treatment. Excesses are usually the result of previous over enthusiastic treatment, but they may be due to disease processes as well, for example the excess of extracellular fluid present in cardiac failure, the nephrotic state of nephritis, or in the cirrhotic.

Deficiencies obviously result in varying degrees of dehydration as are manifested clinically by dryness of skin and loss of turgor, lack of sweating, softening of the ocular bulbs, dryness of the mucous membranes, concentration of urine, etc., and the effect of dehydration depends upon the amount of water lost, the rate at which the loss occurs, and the amount and type of electrolytes lost. Replacement of this water and electrolytes should be made at a rate about the same at which it was lost. Thus, the patient with sigmoid obstruction, for example, due to cancer who has lost his fluid over a period of many days should have replacement over a similar period of time, since the loss is fairly equally distributed over the plasma, interstitial and intracellular fluid spaces. On the other hand, the patient dehydrated due to severe vomiting and diarrhea for the past ten-12 hours needs to have his fluid replaced rather rapidly in order to maintain effective circulating blood volume. The same contrast is seen in the patient experiencing hemorrhage—slow, chronic, small quantity bleeding versus rapid, acute loss.

Replacement Fluids

The composition of replacement fluids required in dehydration depends upon the rate of dehydration and the extent of the electrolyte depletion in remaining fluids. In slow dehydration it is obvious that a large proportion of the water loss is from the intracellular compartment. Replacement requires water, potassium and possibly phosphate for restoration, and a relatively small amount of sodium chloride and bicarbonate for the extracellular deficit. More rapid dehydration is largely extracellular fluid in its character and here the replacement required is water and electrolytes according to the proportions in which they exist in the extracellular fluid. For straightforward expansion of the extracellular fluid space either Hartman's solution or a proportion of two-thirds isotonic sodium chloride and one-third sodium bicarbonate or one-sixth Molar lactate is

better than the administration of normal saline alone. However, with vomiting, chloride loss is often in excess of sodium, and saline is the fluid of choice.

To conclude the consideration of the patient's "static debt," we must emphasize again that laboratory determination of hemoglobin, and even the hematocrit, frequently fails to reveal the true functional capacity of the blood vascular system, and that measurement of the circulating blood volume by whatever means are available provides information which may truly be life-saving for the seriously ill patient.

Summary and Conclusions

All patients, and in particular the aged or seriously ill, can more intelligently be cared for if a few fundamentals concerning fluid and electrolyte balance are observed:

- (1) The baseline requirements of water and electrolytes for the individual patient, with consideration of his age, body conformation, disease, and atmospheric environment, are taken into account and tabulated.
- (2) Losses of fluid and electrolytes, both visible (and measurable) and occult, are considered daily or more frequently.
- (3) Losses resulting in deficiencies which are present when the patient is first observed are estimated clinically and measured in the laboratory.
- (4) The total daily intake of water and electrolytes required will be the sum of the baseline requirements, plus the dynamic loss, plus a proportion of the deficiencies in water, electrolytes and blood volume.
- (5) A daily or more frequent evaluation of the status of the baseline and dynamic loss and a critical evaluation of deficiencies at the beginning of therapy enable the physician to evaluate the problems of maintaining a normal or nearly normal intra- and extracellular fluid structure for the patient before, during, and after a traumatic experience.
- (6) It should be remembered that parenteral replacement is always a temporary and inadequate substitution for the gastrointestinal tract, and oral intake should be resumed as soon as returning function permits, supplementing parenterally until oral intake is adequate in water, electrolytes and calories.

384 Peachtree Street

PEDIATRICIANS PLAN MEETING DURING ANNUAL SESSION

The Georgia Chapter of the American Academy of Pediatrics will meet Saturday, May 5, 1962 at 2:00 p.m. at Lebanon Plantation, eight miles from Savannah.

Fellows without transportation will be taken by automobile from the DeSoto Hotel at 2:00 p.m. At the end of the meeting there will be a reception and supper.

POSTPARTAL HEART DISEASE

H. Clayton Courson, M.D., *Thomasville*

■ *The literature is reviewed and the pathology of this rare disease is discussed*

IN 1870 VIRCHOW¹ described an "idiopathic myocardial degeneration" occurring somewhat frequently in women dying in the puerperium. In 1880 Porak² confirmed Virchow's work but correctly concluded that this type of cardiac disease was "more morbid than mortal." Blackner³ in 1907 and Campbell⁴ in 1923 indicated that myocardial disease not accompanied by valvular lesions was important in the production of congestive heart failure during late pregnancy and the puerperium. In their description of four cases of myocardial failure which occurred during the puerperium, Herman and King⁵ noted that these patients had no history or clinical findings compatible with the usual kinds of heart disease. On the basis of a large series of autopsies Williams⁶ concluded that 1.5 per cent of deaths occurring during the puerperium from cardiac causes were due to "idiopathic myocarditis." Hull and his associates^{7,8} in 1937 and 1938 reported a series of 80 patients with congestive heart failure, 54 of whom had what they described as the *syndrome of postpartum heart disease*. Gouley, McMillan and Bellet⁹ in 1937 described seven additional cases including four deaths with autopsies. More recently, other authors have contributed reviews and additional case reports.¹⁰⁻¹⁵ However, the etiology of this syndrome is still obscure.

Clinical Features

Some women with postpartal heart disease may have mild to moderate dyspnea, palpitations and ankle edema late in the third trimester of pregnancy which disappears following delivery. However, more severe congestive failure may recur after activity is resumed in the puerperium.⁹ Typically, this disease begins insidiously from two to six weeks after an apparently normal gestation and delivery with cough, dyspnea, and pedal edema.¹⁰ Marked cardiomegaly may develop with a regular tachycardia and, frequently, with a diastolic gallop also. Some

patients have diastolic hypertension with a narrow pulse pressure while others develop both a systolic and diastolic blood pressure increase. A systolic apical murmur may be heard. Distended neck veins, pulmonary congestion and hepatomegaly often accompany the edema which commonly increases in severity. Seriously ill patients may develop biventricular failure, serious effusions and Hull's diagnostic triad of anasarca, pulse of small volume and gallop rhythm. Less commonly the disease may present as an episode of acute left ventricular failure.

Embolic phenomena are common complications of this disease, frequently involving the lungs and brain. These begin in the heart as mural thrombi, and are believed to result either from stasis formation in the dilated chambers or as a result of severe muscle degeneration.⁹

Hull^{7,8} noted this disease to be more common in negroes than whites. Its incidence is also increased in primagravidas. These patients have also been found to have an increased incidence of twins, toxemias of pregnancy and deficient diets.

E.K.G. Findings

The most common electrocardiographic findings have been varying degrees of T-wave inversion and ST segment changes have also been reported. The abnormalities indicate nonspecific myocardial injury. Brocato¹⁵ reported patients with ST segment depression in addition to T-wave inversion. Low voltage has been found by some authors^{7,12} believed due to extrinsic edema. Melvin¹⁰ observed that the electrocardiographic changes in these patients do not vary from day to day as they do in patients with rheumatic fever or Diedler's myocarditis. Roentgenograms of the chest almost always reveal moderate to marked generalized cardiac dilatation with no selective chamber enlargement. Pulmonary congestion is also frequently seen.

Laboratory studies have demonstrated albuminuria believed by Hull⁷ to be greater than in congestive failure from other causes. A moderate to severe anemia occurs in many patients.^{7,9} Total leukocyte counts not infrequently are slightly elevated.^{9,15} No other important abnormalities have been noted.

Etiology

The etiology is still obscure. Of the more than a dozen suggested causes all remain unproven. A partial list of possible agents includes toxemia of pregnancy, puerperal glomerulonephritis, nutritional deficiencies, metabolic disorders or endocrinopathies, puerperal infection, water retention and hypoproteinemia of normal pregnancy, previous cardiac disease damaged by an unknown puerperal factor, calcium deprivation, proteolytic enzymes, ergot, anemia, cor pulmonale, lactation, premature resumption of full activity, essential hypertension and Fiedler's myocarditis.

Most of these possibilities are supported by certain factors. For example, both toxemia and postpartal heart disease occur frequently in young primiparas, especially negroes. Both have a high incidence of twin pregnancies. Postpartal heart failure developing within one week postpartum and followed some two to three weeks later by acute hemorrhagic glomerulonephritis has been reported in some cases by Musser, Sodeman, and Turner.¹¹ According to Hull,⁸ the clinical manifestations of postpartal heart disease and cardiac beriberi are identical if the neurologic manifestations of the latter are disregarded. A number of patients with postpartal heart disease have lived on diets deficient in vitamins and protein during pregnancy. Meadows¹⁴ has called attention to the marked similarities between the congestive failure of postpartal heart disease and that produced by desoxycorticosterone. An interesting study by Sibling¹³ on the role of respiratory viruses in heart disease showed that four cases of postpartal myocarditis occurred in a series of 21 cases of viral myocarditis. One patient had primary atypical pneumonia virus and another a mixed influenza A and B infection. The remaining two cases were of presumptive viral origin. Gouley et al⁹ believed that both the clinical picture and gross anatomical findings of their cases were similar to Fiedler's myocarditis, and noted that a few reported cases of the latter had microscopic pathological features similar to those of postpartal heart disease. In some instances, however, no plausible causative factors are apparent.

Pathology

The gross and microscopic pathologic findings are thought by some to be constant and distinctive.

The gross findings include a soft, pale, flabby, dilated myocardium with little or no ventricular hypertrophy and with apparently normal pericardial and epicardial surfaces. Meadows¹⁴ found that heart weights varied from 260-650 Gm. with 60 per cent of the cases varying from 470-525 Gm. Antemortem ventricular mural thrombi are frequently found within the trabeculae carneae. They are believed to form as a result of poorly contracting ventricles, stasis of blood and subendocardial myocardial degeneration. Valves and coronary arteries are usually normal. Microscopic findings include focal and, to a lesser extent, diffuse areas of myocardial degeneration with irregularly sacculated muscle fibers which may appear "wavy" because of cytoplasmic loss. Gouley, McMillan, and Billet⁹ noted that myocardial nuclei remain prominent in areas of sarcoplasmic degeneration. Sometimes these nuclei become arranged in parallel rows as if being compressed by the surrounding myocardium. The degenerating foci become infiltrated to varying degrees with lymphocytes and, to a lesser extent, with neutrophils and eosinophiles. Meadows¹⁴ also found that these necrotic areas were most intense in the subendocardial region, especially in places underlying thrombus attachment. Hemorrhage into areas of degeneration is not infrequent. Older lesions become infiltrated by fibroblasts and are eventually replaced by acellular scars.

Therapy

The response to treatment is less striking than that seen in patients with heart failure due to the more common types of heart disease. Nevertheless, digitalis, mercurial or chlorthiazide diuretics and salt restrictions should be employed in the usual manner. Mechanical removal of collections of fluid is usually more efficacious. Oxygen and opiates should of course be used as usual during acute attacks of dyspnea. Patients should remain on complete bed rest at least until several weeks after all edema has completely subsided. Resumption of activity following this period of bed rest should be very gradual. Since embolic episodes occur not infrequently, the question arises as to whether anticoagulants should be used prophylactically. This is not believed to be wise in view of the occurrence of myocardial hemorrhages even without these drugs.¹² However, once embolization occurs, anticoagulant therapy is indicated. Steroids have been suggested as possibly being effective if the previous measures fail, but should be used with great care and only after preliminary hormone assays. The immediate outlook for the majority of these patients is good in spite of the poor response noted to standard therapy for congestive heart failure. Since this condition may

POSTPARTAL HEART DISEASE / Courson

recur with additional pregnancies, sterilization should be considered if repeated bouts of postpartal heart failure occur.

Gordon Avenue

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NEW REGULATIONS ADOPTED FOR CANCER PROGRAM

Georgia's State Aid Cancer Program which has won wide acclaim all over the United States as an excellent cancer treatment program was, as many of you recall, in serious financial troubles just a few months ago. A 20 per cent gain in the number of cases over previous years compounded by a 30 per cent increase in hospital rates put such a severe strain on allocated funds as to seriously jeopardize the continuation of the program on the same scale as it has previously operated.

Because of these conditions the State Board of Health at its March 1st meeting adopted additional rules and regulations having the general effect of tightening up on new admissions to the program. The State Board held to the opinion that the application of new regulations and the frugal utilization of surplus funds would permit the State Aid Cancer Program to continue operation. In the interest of informing MAG members of these new regulations, the action of the State Board of Health on this matter is listed below.

1. Policies relating to the re-certification of state-aid patients.

Generally speaking, the original certification refers only to the lesion for which the patient is referred. Subsequently, re-approval will be required for the care of some new and unrelated condition. Moreover, since the financial status of the patient may improve, routine re-approval at certain intervals is desirable.

(a) If the lesion for which a patient is referred proves to be non-malignant, the patient ceases to be a state-aid case. He is not eligible for further services unless re-approved.

(b) Patients who have received treatment for one type of malignancy may not return for the evaluation of some new and unrelated condition unless re-approved.

(c) Re-approval of skin cancer patients will be required routinely every three years.

(d) After a period of three years, patients who remain under observation may not be readmitted to the hospital unless re-approved.

2. Biopsies should be obtained on an outpatient basis if at all possible. This also applies to other diagnostic procedures.

3. Hospitalization for diagnostic study is limited to three days. The three day limit also applies to readmis-

sions for study purposes.

4. Patients may not be admitted to the hospital more than three days prior to surgery; that is, not more than three preoperative days will be paid for.

5. Re-admission of patients following definitive therapy.

(a) Patients may not be re-admitted to the hospital except for specific therapy which may be expected to provide significant palliation. Patients may not be re-admitted for supportive therapy.

(b) Patients may not be re-admitted without the knowledge and approval of the clinic director.

(c) Except for specific therapy as indicated under (a) above, patients with advanced cancer may not be re-admitted without the prior approval of the Director of Cancer Control.

6. Patients may be admitted for one day for a blood transfusion. For multiple transfusions, patients may be admitted for as many as three days.

7. Patients may be admitted for not more than four days for chemotherapy.

8. If a patient must be admitted for X-ray therapy, payment will be made for hospital or domiciliary care at the rate of \$5 per day. Any exception to this policy must be approved in advance by the Director of Cancer Control.

9. Patients may not be admitted for treatment of benign conditions unrelated to the patient's cancer.

10. The cancer clinics are not general diagnostic clinics and they are not expected to accept patients for study unless there is a clear indication of malignancy. In the absence of a reasonable expectation of malignancy, it is not permissible to admit patients for study merely to establish a diagnosis or to "rule out cancer."

11. If it appears that a referred patient may be able to pay for examination or treatment, the clinic is under no obligation to accept the case. A re-appraisal of the patient's financial status may be requested.

12. Hospital insurance must be collected and deducted from the patient's bill.

13. Bills for services rendered are checked against the monthly clinical reports which must provide sufficiently detailed information to justify the charges which are made.

THE SURGICAL SIGNIFICANCE OF THE NON-VISUALIZING GALLBLADDER

S. A. Roddenbery, M.D. and A. B. Conger, M.D., *Columbus*

■ ***An absent gallbladder shadow following a properly performed cholecystogram gives strong evidence of an abnormal gallbladder as proved by surgery***

Introduction

ONE OF THE CHIEF fascinations about surgical practice is the opportunity to correlate the clinical diagnosis with the actual pathological process at the operating table. In our practice we have had a particular interest in performing surgery on the patient with the history and physical findings of gallbladder disease, but in whom the properly performed gallbladder series on one or more occasions has shown "non-visualization." Immediately prior to opening the peritoneum, there is an intense excitement and speculation as to whether or not the gallbladder is diseased and whether or not radiolucent stones are to be found.

When the possible causes of failure of gallbladder visualization on the cholecystogram have been excluded, we have come to place considerable confidence in the finding of an absent gallbladder shadow in the patient who has the history and physical findings to support a diagnosis of cholecystic disease.

The continuing interest in this subject has stimulated us to make a study, not only of our own experience, but of the combined results of our entire surgical staff at The Medical Center, a 290 bed general hospital.

Method of Study

The approach has been to make a careful study of all cholecystectomies performed at this hospital from 1951-1960. All medical records pertaining to each case have been examined and analyzed with particular reference to the x-ray studies of the gallbladder, the findings at operation, and the gross and microscopic tissue evaluation. There were 531 cholecystectomies performed in this ten-year period by

16 members of our surgical staff. Fifty-nine (11 per cent) of these cases were done by the surgical residents under the supervision of the attending surgeons. Particular attention has been given to the group of patients who showed only a non-visualizing gallbladder on all their cholecystograms. This paper will be limited primarily to this phase of study, and a more comprehensive report of the entire cholecystectomy experience is being submitted for publication in the near future.

Since selecting the title of this paper, we have come to feel that a more accurate name for reporting the cholecystogram, in which the gallbladder fails to show up after the usual preparation, is the term "absent gallbladder shadow."

X-Ray Examination

X-ray examination is made by means of a plain scout film followed by a cholecystogram. The plain film will reveal stones in about ten per cent of the patients in whom they are present. Only those stones rendered opaque by their calcium content will be seen on this examination.

The evening prior to cholecystogram, the patient ingests the dye. Twelve hours later, on an empty stomach, films are taken of the gallbladder area. If the gallbladder is well outlined by the dye, a fatty meal is given the patient, and the gallbladder is again x-rayed to determine its ability to empty normally. There has been less emphasis in recent years on the importance of the gallbladder contracting after a fatty meal as a criterion of good function. When a combined GB-GI Series is done, the response to the fatty meal is frequently omitted entirely. In this regard, it should be pointed out that, in a few instances, such lesions as polyps of the gallbladder can only be detected after gall bladder contraction

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in response to the fatty meal. The fatty meal test should be included if the maximum information possible is desired relative to the gallbladder status.

Cholecystograms are usually interpreted as follows:

1. When the gallbladder is well outlined by a concentrated, uniform shadow and it contracts well following a fatty meal, one may safely conclude that the gallbladder under study is normal. In 98 per cent of the subjects examined, this interpretation will prove correct. One may conclude that the liver cells are capable of excreting the dye, that the bile ducts are patent, and that there is no disease of the gallbladder walls.

2. When the gallbladder is well outlined by the dye but contains negative shadows, the outline demonstrates that the liver cells can secrete the dye which enters the gallbladder where it is concentrated to a degree that is roughly proportional to the amount of inflammation of the gallbladder walls, while the negative shadows represent non-opaque gallstones. To make certain that these suspected stones are not outside the gallbladder, it is necessary to take more than one film with the patient in more than one position. The diagnosis of stones made following such an examination as described will be accurate in 96 per cent of the cases.

3. When the gallbladder shadow is absent, this means that the liver cells are unable to excrete the dye, that an obstruction in the bile duct exists preventing dye from passing into the gallbladder, or that the gall bladder mucosa is so diseased that it cannot concentrate the dye, or, in cases where the dye was administered orally, that it was not absorbed from the intestinal tract as may occur in nausea and vomiting and diarrhea. When the gallbladder shadow is absent, it should be repeated with a double dose of dye. If, again it is not seen, this is strong evidence that the organ is diseased.

4. When only a faint gallbladder shadow is visualized, this suggests that the patient is very obese or the x-ray technique is erroneous, or, that one of the factors above causing an absent shadow is present to a lesser degree. The finding of a faint gallbladder shadow in a cholecystogram usually is attributable to impairment of that organ by disease. However, this sign is too unreliable to serve as a basis for operation unless well documented by other clinical findings or by demonstrating gallstone defects within the faint shadow.

5. When the gallbladder can be visualized and there is constant irregularity of the outline with a

marginal defect constant in the same portion of the gallbladder regardless of the position of the patient, a papilloma of the gallbladder is nearly always present.

Organization of Material for Study

For purposes of organization, all cases were placed in one of the four following groups for a detailed analysis:

GROUP I: 76 cases—consisting of all cases in whom there was no evidence on the chart that any gallbladder x-ray studies had ever been done. This included primarily all acute surgical abdomens in whom the gallbladder was removed as an emergency surgical procedure, and in whom the diagnosis, when made preoperatively, was done on clinical grounds alone.

GROUP II: 105 cases—consisting of those cases in whom there was historical evidence on the chart that x-ray studies revealing a pathological gallbladder had been done, but there had been no studies made in this hospital X-ray Department. In many instances, these x-rays had been made in the physician's private office.

GROUP III: 260 cases—consisting of all cases in this study in whom one cholecystogram had been done in this hospital.

GROUP IV: 90 cases—consisting of all cases in whom more than one cholecystogram had been done in this hospital.

Grouping of Cases for Study

	No History of GB X-rays	History of GB X-rays Elsewhere	One GB Viz	More than One Viz	Total Cases
Inflammation	15	8	31	8	62
Stones	57	91	218	79	445
Carcinoma	—	1	1	—	2
Polyp	—	—	1	—	1
Cholesterolosis	1	4	8	2	15
Normal	2	—	1	1	4
Gunshot wound	1	—	—	—	1
Totals	76	105	260	90	531
Stones	83.7%				
Inflammation	11.4%				
Miscellaneous	4.9%				

The Surgical Pathology of the Absent Gallbladder Shadow

In this series of 531 cholecystectomies, there were 83 patients who had had only one cholecystectomy which revealed an "absent gallbladder shadow." Thirty additional patients had from two to four gallbladder series each but also revealed only an "absent gallbladder shadow." The total of 113 cases who showed no gallbladder shadow are listed according to the pathology found as follows:

Correlation of the Absent Gallbladder Shadow with the Surgical Pathology

	One GB Series	Two GB Series	Three GB Series	Four GB Series	Total Cases
Acute Gallbladder with Stones . . .	20	10	1	—	31
Chronic Gallbladder with Stones . . .	41	12	2	1	56
Chronic Gallbladder with Stones and Common Duct Stones	2	—	—	—	2
Chronic Gallbladder with Stones and Cholesterosis . . .	2	—	—	—	2
Empyema of the Gallbladder with Stones	2	—	—	—	2
Carcinoma of the Gallbladder with Stones	1	—	—	—	1
Acute Gallbladder	4	—	—	—	4
Chronic Gallbladder	9	4	—	—	13
Chronic Gallbladder with Pancreatitis . . .	1	—	—	—	1
Normal Gallbladder	1	—	—	—	1
					113

In the above table 94 of the 113 gallbladders removed contained gallstones. This results in an incidence of stones in 83 per cent of the cases. The other 17 per cent showed either acute or chronic inflammation without the presence of stones with the exception of one case which showed a normal gallbladder.

Comments

It is axiomatic with most surgeons that the gallbladder containing stones should be removed, provided the patient has a reasonable life expectancy and is in otherwise good health. The presence of in-

capacitating symptoms or the development of complications from stones make cholecystectomy more urgent, even though the general health and life expectancy are not as desirable as they might be. In this predicament additional risks accomplishing the surgery must be assumed. To borrow a phrase from Dr. Boyd's "Textbook on Pathology," gallbladders containing stones are like "houses of ill-repute from which trouble is apt to brew at any minute."

In our experience, the patients who have had one or more cholecystograms which revealed only an absent gallbladder shadow, show an 83 per cent incidence of stones. This would seem to indicate to us that in a patient who has a properly performed cholecystogram showing an absent gallbladder shadow, there is strong x-ray evidence to support clinical findings of gallbladder disease. If there is any reasonable doubt of the diagnosis on the basis of the clinical evidence or of inadequate performance in the preparation for, or the execution of the cholecystogram, studies should be repeated until satisfactory standards have been met.

Conclusions

Facts have been presented showing that the cholecystogram, properly performed but revealing only an *absent gallbladder shadow*, gives strong evidence of an abnormal gallbladder as proven by surgery. Our surgical experience in this situation has yielded stones in 83 per cent of the gallbladders removed, and acute or chronic disease without stones in the remainder of the 17 per cent of cases with the exception of one normal gallbladder which was removed.

711 Center Street

MEDICAL EDUCATION LOAN GUARANTEE PROGRAM ACTIVATED

Medical students, interns and residents can now receive financial support through a program which has been worked out and accepted by the Board of Directors of the American Medical Association Education and Research Foundation. This plan will assist students who need financial help at any stage of their medical education. They must be in good academic standing and U. S. citizens. Medical students are required to attend one of the American medical schools approved by the Council on Medical Education and Hospitals of the AMA. Interns and residents are eligible if they take their training in a hospital approved by the council.

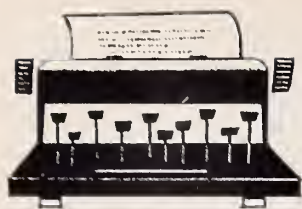
In general, the program will be similar at all levels of medical education, both graduate and undergraduate. In order that the plan operate effectively, medical schools, the banking industry and the AMA will make the details of this plan known to the students and provide application materials to students who need to borrow. Private banking institutions will make the loans

and the AMA-ERF will guarantee the loan so that the interest cost to the student will be minimized.

With respect to the total program, it is necessary for the AMA-ERF to maintain a loan security or guarantee fund equal to at least eight per cent of all notes co-signed. With respect to borrowers, the loan limit is \$1500 in any 12 month period and \$10,000 total within a seven year period. A further limitation is that the total of all accumulated loans for educational purposes may not exceed \$15,000.

The program cost is contained in three items: administrative expenses, losses through defaults and interest charges. A new note, known as an "interim note" will include the principal and interest from the previous note and the principal and interest for the new loan to be granted.

Interested students may consult their medical school dean and interns and residents should get information from the Chief of Service or the Program Director of their hospital.



Measles Vaccine

MEDICAL INVESTIGATORS are looking forward to rewriting the textbook section on measles in the near future. Next year or soon thereafter, doctors in the United States may be able to offer their young patients one of two effective measles vaccines with the expectation of better than 90 per cent protection. These vaccines are eagerly awaited by parents and physicians alike.

In the United States, in an average year, the number of children contracting measles approaches four million. Of these, about five per cent may have a subclinical or an atypically mild infection. The unfortunate majority, however, will have significant illness. The virus infection alone may be severe, but its toll does not stop there. Bacterial complications, particularly pneumonia and otitis media, are not uncommon. Measles encephalitis may occur as often as one in 400 cases. The extent of the contribution of the measles virus to mental deficiency is yet unknown. In an average year, 500 measles deaths occur—more than any other of the contagious diseases.

Basic Research

As a result of pioneering research in the laboratory of Dr. John Enders at Harvard, an attenuated strain of measles virus, designated the Edmonston strain, was isolated and adapted to tissue culture. From this original strain two types of measles vaccines have been developed, one an attenuated live virus vaccine and the other an inactivated and concentrated vaccine. As with vaccinia, administration of the attenuated measles vaccine results in a systemic illness. The inactivated or killed vaccine, with a high concentration of measles virus antigen, stimulates the patient to produce antibodies without undergoing an actual infection.

The systemic illness resulting from the live vaccine in present experimental use resembles mild measles in some children. Fever tends to appear from the sixth to the ninth post-vaccination day. A temperature elevation above 100 degrees occurs in about 85 per cent of vaccine recipients, with about 60 per cent having an elevation of 102 degrees or higher. A rash appears in 35 to 50 per cent of children about nine days after inoculation. In most instances it is mild.

Since varying the dose of live virus vaccine neither aggravated nor diminished these systemic symptoms, investigators turned to gamma globulin which has been used so successfully in modifying naturally acquired measles. It was found that concurrent administration of .01 ml. per pound of measles immune gamma globulin did significantly reduce the systemic manifestations. However, if too much gamma globulin was given in relation to the dose of virus vaccine, the vaccination did not "take."

Killed Vaccines

The concentrated killed measles virus vaccines so far developed do not cause a clinical reaction as is found after use of the live vaccine. However, to insure effective protection several injections are needed. At present, immunization schedules call for a series of three injections of 0.5 ml. of killed vaccine to be given at three to four week intervals.

Research on live measles vaccine is being concentrated on further attenuation of the virus in order to allay the systemic symptoms following its use. Success in this effort—and preliminary reports are promising—would make the live vaccine practical and wholly acceptable in general practice. Elimination of the necessity to use modifying doses of gamma globulin would be a most welcome simplification.

Research on the killed vaccine is being directed this year to extensive field trials in susceptible populations. Multiple antigen vaccines combining inactivated measles and polioviruses are also under study. The prospect of other additions to this combination such as diphtheria, pertussis and tetanus may be anticipated.

Mechanisms of Immunity

The duration of immunity conferred by the two vaccines may well be the determining factor in their final acceptance. Presumably, the live attenuated vaccine results in life long immunity since it causes a mild systemic infection. The inactivated vaccine confers an immunity which may be of shorter duration. Appropriate booster doses may be indicated. One interesting possibility is the use of a serial combination of the two vaccines. One or two doses of

the inactivated vaccine preceding a dose of the live vaccine may well offer maximum protection with a minimum of undesired systemic reactions.

Such an immunization schedule is currently under study in DeKalb County, Georgia, as part of a collaborative investigation underway in four other county health departments. In each case a thousand susceptible school children are included in this

double-blind placebo controlled study. Results will be available only after measles epidemics hit these areas. These could be among the last epidemics to occur in Georgia.

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County Society Activity—1962

Presidents and secretaries of the Association's component county medical societies gathered in Atlanta to attend the Medical Association of Georgia 4th Annual County Medical Society Officer's Conference. This two-day session was convened February 17-18, 1962 and a few words of editorial comment about this meeting are apropos — in that the results of the meeting can only be measured in terms of county society activity.

Basically, the conference had two objectives. The first aim was to encourage the leaders of the profession to speak out; to tell the public medicine's views about the threat of socialized medicine. Campaigning for a viewpoint is the American way. Every public platform and speaking engagement should be utilized by physicians if the voting public is to become aware of the issues favoring the doctors that have a direct bearing on health care. As has been said, "the time is now," and county society officers were urged to become active by becoming the voice of medicine in their community.

The second conference objective was to stimulate county society activity in the fields of medicine and religion, legislative matters and insurance and economics. This portion of the meeting was titled

"What We Need To Do In 1962." A panel of clergymen and physicians presented the need for better health care through cooperative effort on the part of the doctor and the minister. Discussion of the impact of legislative measures on medical care was emphasized. Physicians were informed about "relative value schedules" and their usage.

The conference closed with an address on the subject of leadership for the profession — getting the job done by effectively serving your county society.

After the session adjourned, a county society president stated that while the meeting was interesting and instructive; the proof of the pudding was whether or not the doctors cared enough to do something about these matters. The challenge is there and medicine will succeed or fail in proportion to the county society effort. Remember well, it is the county medical society that is the top unit of the profession — the state association is merely an instrument of the county society for statewide activity as is the AMA set up to serve county and state societies. Let us then judge the merits of the Conference on the basis of its effect on county society leadership.

On Counting Calories

THE GROWING PUBLIC concern over the problem of obesity is an obviously healthy sign. However, one unfortunate result of this interest is the fertile field thus opened to weedy, opportunistic ventures in weight reducing — the "easy way."

The subject of this article is a book brought to my attention by a desperately obese patient. This book is on sale at a grocery super-market. In another

department of this super-market capsules are on sale. These were recommended in the book and contain a combination of safflower seed oil and vitamin B₆. *Calories Don't Count* was written by Herman Taller, M.D. Dr. Taller, a gynecologist and obstetrician, is alleged to have lost 65 pounds on the diet outlined in his book. Practicing in New York, he is said to see obese patients from all over the

United States and even South America. A review of this book and the Food and Drug Administration seizure of 1600 copies may be found in a recent issue of *Consumer Reports*.

Dr. Taller writes that only by eating large quantities of fat with avoidance of carbohydrate may weight loss be accomplished in the obese patient. An alleged metabolic block at the pyruvate level limits utilization of carbohydrates for energy and diverts this metabolite to fat deposition. On the other hand, ingested fat is converted to energy in unlimited quantities. To quote:

"But an obese person eating large quantities of fat is stimulated to burn fat three times as strongly as a lean person. The obese person not only burns the fat he eats; his system gets so fired up that it burns the fat he has accumulated over the years. . . . You lose and you continue to lose until your body reaches its normal weight. Then you stop losing, because your body will adjust; it will burn fat not at a fat man's rate but at a normal rate. More than 95 per cent of all obese people who bring their bodies down to normal on a high-fat diet find their bodies remain normal."*

Pennington Diet

Dr. A. W. Pennington is credited with the above theory which Taller then embellishes with polyunsaturated oil to improve arteriosclerosis, eczema, sinus trouble, heart burn, general disposition and sexual drive. The diet then becomes ". . . my new nutritional principle."

Interest in this book stems from several factors. There is presented an attractive alternative to the difficult orthodox weight reducing plans. This is based on a unique metabolic theory which is speciously consistent and serves the compulsive need to appear "scientific." Finally, questions are brought to mind on the role of magic in the practice of medicine.

The idea that there is any metabolic recognition of the derivation of carbon fragments and selective oxidation of those originally fat ignores biochemistry at its most elemental level. In 1955, Dr. Sidney C. Werner performed a balance study comparing weight reduction on a high-calorie, high-fat diet as recommended by Pennington to that on an isocaloric regimen high in carbohydrate. The diets contained 2870 calories. The high fat diet had 242 grams of fat, 122 grams of protein and 52 grams of carbohydrate. The control diet was composed of 146

grams of fat, 104 grams of protein and 287 grams of carbohydrate. The results of the study were clear cut in that the two diets were handled similarly by the body in terms of the response of body weight.

Metabolic Needs

An interesting facet of this study is the surprising fact that a proportion of the subjects lost weight while taking in 2870 calories. However, this should not be surprising when considering the metabolic needs of some highly active obese subjects. The 242 grams of fat in the high fat diet was generally considered unpalatable and resulted in diarrhea in some of the cases. Taller states that individuals eating as much of the fatty diet as they can hold will lose weight and offers for proof of the above-mentioned theories the fact that it works. The unpalatability provides its own caloric governor so that it is doubtful that many eaters will exceed 2870 calories. The weight loss that may occur on the high fat diet is perfectly well understandable in terms of current metabolic theory without the necessity of invoking any bizarre, arm-chair concepts.

However, in a certain sense, Taller may be correct in the assertion that calories don't count. Practitioners need no reminder of the difficulty of weight reduction. It is not enough to prescribe a diet deficient in calories. Therapeutic response is directly proportional to the degree of doctor-patient inter-action at a trying level for the over-worked practitioner.

One look at the wretched ogre who was once the jolly fat boy is enough to realize the tremendous psychic support in a square meal. It must somehow be replaced by activity other than eating. Strong forces, intra-personal and social, bring about the obese patient's overeating. People generally tolerate the jolly fat boy better than the wretched ogre.

Application

There are those who would use suggestion to support the needs of the dieting patient. This, together with the unpalatability of the high fat diet, may work. Dr. Taller approaches the problem of obesity with fervor close to messianic zeal. To this end may the facilities at Idlewild Airport be clogged with Dr. Taller's patients. However, pessimism, born out of repeated disappointment, dictates that this fad will go the way of all such fancy and soon be buried out of public sight.

The brand of medicine in our society demands a scientific — truly scientific approach to problems. Severe obesity is analogous to the problem of far-advanced tuberculosis: it should not have been allowed to develop in the first place. Just as the incidence of far-advanced tuberculosis has been improved by early detection and treatment of tuber-

*Herman Taller, M.D., *Calories Don't Count* (New York, Simon & Schuster, 1961) pp. 102-3.

culosis, so must the solution to obesity resolve itself in prevention. It is suspected that the prevention of obesity would start from the cradle.

Why do some mothers worry excessively about their children's food intake? How does the obese person view himself? How do his neighbors see him? What does the obese person relinquish through diet? What determines appetite? Answers to these questions are painfully incomplete. Study into

the factors bringing on obesity cuts across several scientific disciplines. The problem is awesome in magnitude. A concerted investigative effort is the next logical step.

B. D. Saffan, M.D.

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Pictures taken at the 4th Annual President's-Secretaries Conference, February 17-18, 1962 at the Dinkler Plaza Hotel in Atlanta, Georgia. Guest speaker on Saturday, February 17 was Congressman Bruce Alger of Texas. See editorial page 187.



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Early, efficient reduction of blood pressure. Only Salutensin combines the advantages of protoveratrine A ("the most physiologic, hemodynamic reversal of hypertension"¹) with the basic benefits of thiazide-rauwolfia therapy. The potentiating/additive effects of these agents²⁻⁸ provide increased antihypertensive control at dosage levels which reduce the incidence and severity of unwanted effects.

Salutensin combines Saluron[®] (hydroflumethiazide), a more effective 'dry weight' diuretic which produces up to 60% greater excretion of sodium than does chlorothiazide⁹; reserpine, to block excessive pressor responses and relieve anxiety; and protoveratrine A, which relieves arteriolar constriction and reduces peripheral resistance through its action on the blood pressure reflex receptors in the carotid sinus.

Added advantages for long-term or difficult patients. Salutensin will reduce blood pressure (both systolic and diastolic) to normal or near-normal levels, and maintain it there, in the great majority of cases. Patients on thiazide-rauwolfia therapy often experience further improvement when transferred to Salutensin. Further, therapy with Salutensin is both economical and convenient.

Each Salutensin tablet contains: 50 mg. Saluron[®] (hydroflumethiazide), 0.125 mg. reserpine, and 0.2 mg. protoveratrine A. See Official Package Circular for complete information on dosage, side effects and precautions.

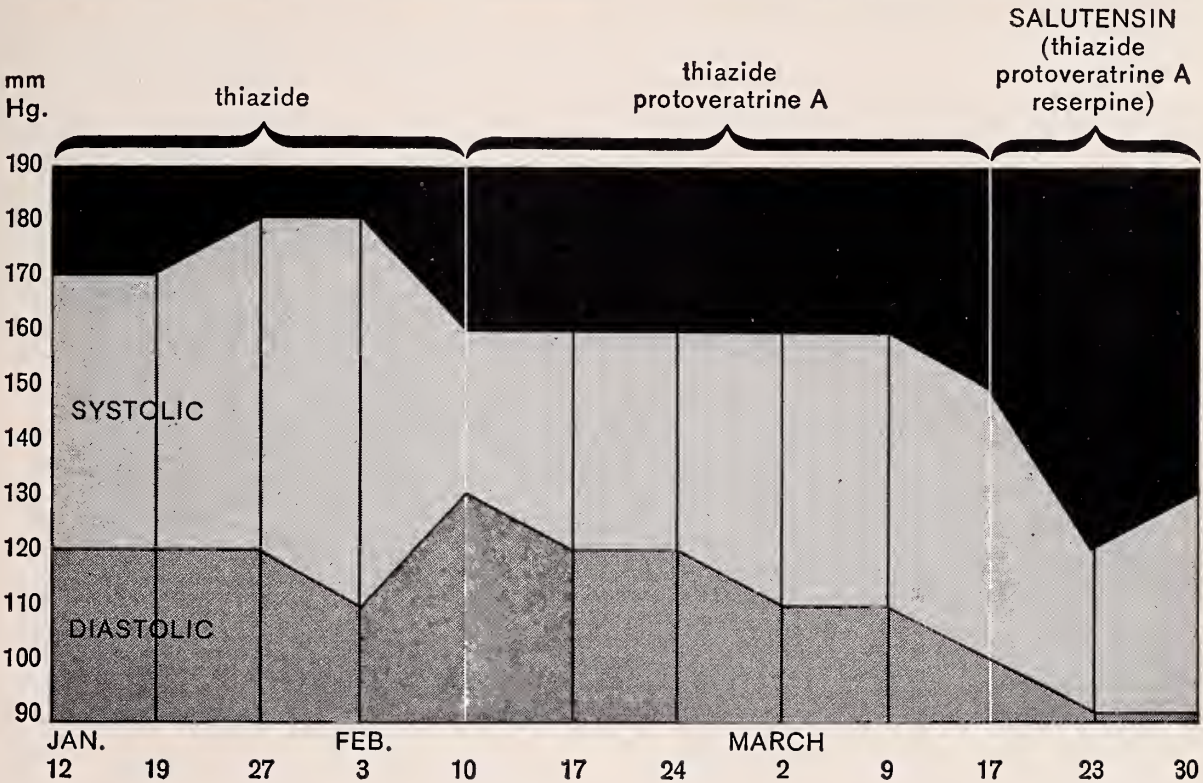
Supplied: Bottles of 60 scored tablets.

References: 1. Fries, E. D.: In Hypertension, ed. by J. H. Moyer, Saunders, Phila., 1959 p. 123. 2. Fries, E. D.: South M. J. **51**:1281 (Oct.) 1958. 3. Finnerty, F. A. and Buchholz, J. H.: GP **17**:95 (Feb.) 1958. 4. Gill, R. J., et al.: Am. Pract. & Digest Treat. **11**:1007 (Dec.) 1960. 5. Brest, A. N. and Moyer, J. H.: J. South Carolina M. A. **56**:171 (May) 1960. 6. Wilkins R. W.: Postgrad. Med. **26**:59 (July) 1959. 7. Gifford, R. W., Jr.: Read at the Hahnemann Symp. on Hypertension, Phila. Dec. 8 to 13, 1958. 8. Fries, E. D., et al.: J. A. M. A. **166**:137 (Jan. 11) 1958. 9. Ford, R. V. and Nickell, J.: Ant. Med. & Clin. Ther. **6**:461, 1959.

**all the antihypertensive benefits of thiazide-rauwolfia therapy plus the specific,
physiologic vasodilation of protoveratrine A**

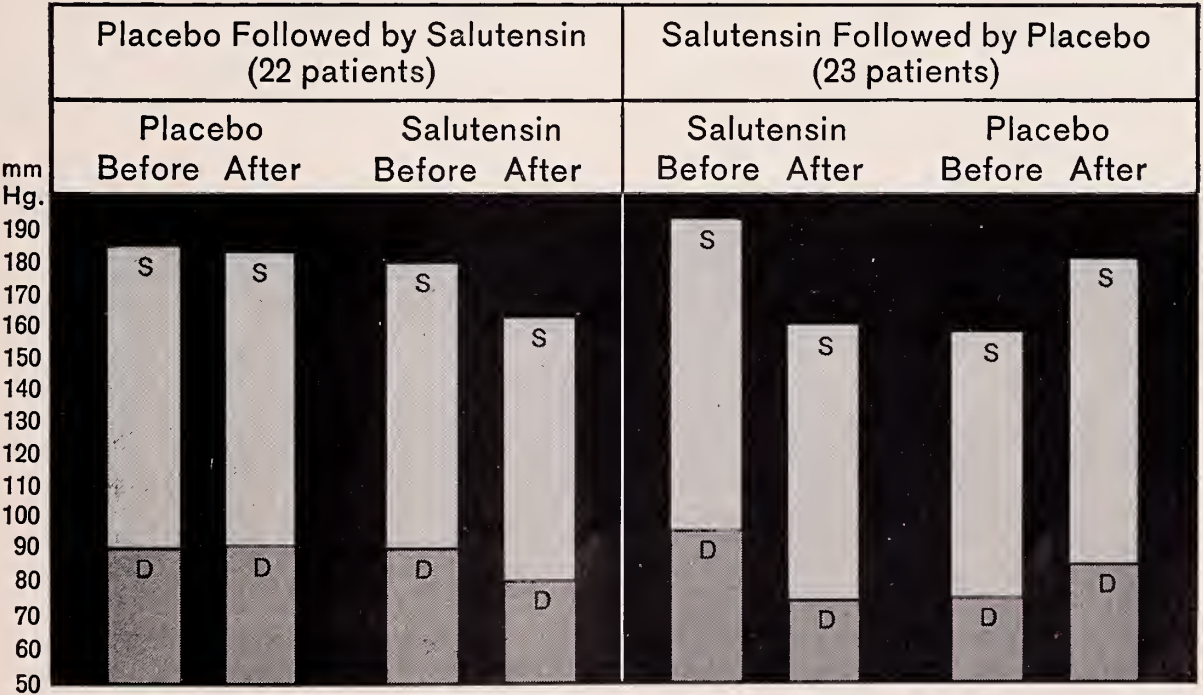
11 WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS BY SERIAL ADDITION OF THE INGREDIENTS IN SALUTENSIN IN A TEST CASE

(Adapted from Spiotta, E. J.: Report to Department of Clinical Investigation, Bristol Laboratories)



3½ WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS USING SALUTENSIN FROM THE START OF THERAPY IN A "DOUBLE BLIND" CROSSOVER STUDY

Mean Blood Pressures—Systolic (S) and Diastolic (D)



In this "double blind" crossover study of 45 patients, the mean systolic and diastolic blood pressures were essentially unchanged or rose during placebo administration, and decreased markedly during the 25 days of Salutensin therapy. (Smith, C. W.: Report to Department of Clinical Investigation, Bristol Laboratories.)

BRISTOL LABORATORIES/Div. of Bristol-Myers Co., Syracuse, N.Y.



1962 CALENDAR OF MEETINGS

State

May 6-9—Annual Session, Medical Association of Georgia.

June 4-9—Postgraduate course in Six Days of Cardiology, Emory University School of Medicine, Atlanta.

Regional

April 23-25—Annual Meeting West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, West Virginia.

April 26-28—Alabama, Medical Association of the State of, Tutwiler Hotel, Birmingham, Ala.

April 29-May 2—Arkansas Medical Society, Arlington Hotel, Hot Springs, Ark.

May 5-9—Medical Society of North Carolina 108th Annual Meeting, Sir Walter Hotel, Raleigh.

May 7-9—Louisiana State Medical Society, Hotel Frances, Monroe, La.

May 8-10—Mississippi State Medical Association, Hotel Heidelberg, Jackson, Miss.

May 8-10—South Carolina Medical Association, Ocean Forest Hotel, Myrtle Beach, S. C.

May 9-13—Florida Medical Association, Americana Hotel, Miami Beach, Bal Harbour.

May 12-15—Texas Medical Association, Austin, Tex.

September 14-15—American College of Obstetricians and Gynecologists, District VII, Little Rock, Arkansas.

September 18-20—Kentucky State Medical Association, Brown Hotel, Louisville, Kentucky.

September 24-25—Tennessee Valley Medical Assembly, Chattanooga, Tennessee.

October 4-6—American College of Obstetricians and Gynecologists, District IV, Barringer Hotel, Charlotte, North Carolina.

National

April 23-28—American Academy of Neurology, Statler-Hilton Hotel, New York City.

April 30-May 2—American Academy of Pediatrics, spring meeting, Statler-Hilton, New York City.

April 30-May 3—American Proctologic Society, Deauville Hotel, Miami Beach.

April—American Association of Pathologists and Bacteriologists, Queen Elizabeth Hotel, Montreal, Canada.

May 6-10—American Association of Plastic Surgeons, Hotel Del Coronado, Del Monte, Calif.

May 28-30—American Ophthalmological Society, The Homestead, Hot Springs, Va.

May 29-June 2—American College of Cardiology, Denver Hilton Hotel, Denver, Colo.

June 4-22—Forty-seventh Session of the Trudeau School of Tuberculosis, Saranac Lake, New York.

June 18-20—American Geriatrics Society, Palmer House, Chicago, Illinois.

June 18-20—American Neurological Association, Claridge Hotel, Atlantic City, New Jersey.

June 19-21—San Diego Symposium on Biomedical Engineering, Stardust Motel, San Diego, California.

June 21-25—American College of Chest Physicians, Morrison Hotel, Chicago, Illinois.

June 21-24—American Therapeutic Society, McCormick Place, Chicago, Illinois.

June 23-24—American Diabetes Associations, Inc., The Conrad Hilton, Chicago, Illinois.

June 23—American Academy of Tuberculosis Physicians, The Palmer House, Chicago, Illinois.

June 24-28—American Medical Association Annual Session, Chicago.

July 23-27—Postgraduate course in Cardiopulmonary Problems in Children, Edgewater Beach Hotel, Chicago.

August 26-27—American Academy of Physical Medicine and Rehabilitation, Hotel Commodore, New York City.

August 30 - September 8—American Society of Clinical Pathologists, Palmer House, Chicago, Illinois.

September 1-4—College of American Pathologists, Palmer House, Chicago, Illinois.

September 6-8—American Association of Obstetricians and Gynecologists, The Homestead, Hot Springs, Virginia.

October 2-5—American Roentgen Ray Society, Shoreham Hotel, Washington, D. C.

October 15-19—American College of Surgeons, Clinical Congress, Atlantic City, New Jersey.

October 27 - November 1—American Academy of Pediatrics, Palmer House, Chicago, Illinois.

October 28-31—American College of Gastroenterology, The Morrison, Chicago, Illinois.

October 29-31—American Association for the Surgery of Trauma, The Homestead, Hot Springs, Virginia.



PRESIDENT'S LETTER

IT'S BEEN A GOOD YEAR

FRED H. SIMONTON, M.D.

AS THE 11TH HOUR of my term of office as your President draws close, permit me to express to each of you my deep appreciation for the honor you have bestowed upon me during the past 12 months. Serving as President of MAG has been a rewarding experience and one which I shall always point to with pride and humility.

It is with mixed feelings that I step down as President at our next Annual Session in May. While I cannot deny a sense of relief to be able to lay down the burdens of office, neither can I deny that I have enjoyed immensely the job which you have permitted me to hold.

In looking back over the past year many things come to mind. Each separate and distinct but when viewed together form a composite picture much the same as the interlocking pieces of a jigsaw puzzle.

I am reminded that this has been a year of achievement, not only for MAG, but for the citizens of Georgia as well. With the cooperation and helpful assistance of the Medical Association of Georgia, the state enacted and implemented a program of medical assistance to our aging population. MAG continues to have a stake as well as a hand in this program. Beginning on January 1st, the effective date of the MAA program, MAG has provided the medical determination so necessary to the success of this new endeavor.

Year of Controversy

In addition to being a year of accomplishment, it has also been a year of controversy. I am happy to say that the controversy has not been medical, but has been political. MAG has been, not by accident, in the front lines of a battle to resist Federal control and intervention in the private practice of medicine. The willingness with which the physicians of Georgia have accepted this challenge has been

an inspiration to all concerned. The time, effort and personal sacrifice of the many doctors who have taken up the fight would overwhelm the imagination of those who have not yet accepted this fight as their personal challenge. At this early date the outcome of the struggle cannot be predicted with certainty. However, it can be stated affirmatively that Georgia has acquitted itself well and will continue to do so as long as the threat of bureaucratic control remains with us.

Year of Accomplishment

The 1961-62 year has seen many precedent-setting events. Among the notable "first" during this period was the special one day, all member meeting held in Macon, Georgia last April. It was the first such meeting in the 113 year history of the Medical Association of Georgia and aside from the historical implications, grave warnings to the medical profession were forecast by many of the participants at this gathering. Many of you attended this meeting and remember well the program presented. The King Bill was a new threat then, and wisely we counceled together to draft our defenses.

MAG was honored to be among the very few state medical associations chosen to appear in person and present testimony before the Ways and Means Committee of the House of Representatives in opposition to the King Bill. In the absence of anything to the contrary we must conclude that MAG was selected because Georgia had a medical story of merit to tell the nation.

Among other 'first' was MAG's selection as a pilot state association for the AMA's new Department of Medicine and Religion. Working with the officers and staff of MAG, the Reverend Paul B. McCleave, AMA Department head selected Geor-

PRESIDENT'S LETTER / Continued

gia as a site on which to develop many facets of the new religious program which AMA was then putting into effect.

It has indeed been a year of controversy and accomplishment. Above all it has been a year of gratifying work for me. I would recommend it highly as a liberal postgraduate education on the subject of medical organization. It has afforded me the opportunity to see at close range what organized medicine can accomplish when acting with a determined united front. It has convinced me more than ever before of the need for medicine at the county, state and national level to close ranks and march in a single column against any who would seek to make arbitrary and unsound changes in the practice of medicine.

Annual Session

As all of you know my successor, Dr. Thomas H. Goodwin of Augusta, will take office at the upcoming Annual Session, May 6 through 9, 1962 to be held in Savannah. Accordingly, this will be my last chance to address you through the President's Page of the *Journal*, and I would like to take this opportunity to say a word regarding the Annual Session.

If it is possible to single out a particular occasion which we might call the rallying point in organized medicine, then such an occasion would surely be our Annual Session. It is perhaps the one most unchangeable aspect of the Medical Association of Georgia. Of course, I don't mean that the format of the meeting does not change, but merely that the concept itself is unchangeable. Our legislative problems ebb and flow with the times. Our problems in medical education, formal and postgraduate, rise and fall. The myriad aspects of the Medical Association of Georgia are in a constant state of flux, from day to day and from year to year. But the Annual

Session is the one thing that we know will always take place.

Against this background I would be remiss if I did not urge each of you to make every effort to attend the 108th Annual Session of MAG. I would like to particularly stress the need for the elected Delegates to attend both sessions of the House of Delegates. We have many problems of such a nature that they can only be resolved through the democratic processes of the House of Delegates and 100 per cent attendance will make the solution of these problems a much easier matter.

At the first session of the House on Sunday, May 6th, our keynote speaker will be Dr. Hugh H. Hussey, Jr., Chairman of the Board of Trustees of the American Medical Association and Dean of the Georgetown University School of Medicine. Dr. Hussey has many years of experience with organized medicine and is knowledgeable and conversant on most of the problems confronting the medical profession today. As a resident of Washington, D. C. he has an insight into problems, though outside the medical field, that are of great importance to the profession. Here is a man with a message and I urge that all Delegates be present for the Sunday, 5 P.M. convening of this session of the House of Delegates.

An excellent program has been arranged throughout the tightly scheduled four days of this meeting. But no meeting can be any better than the attendance. The MAG Board of Annual Session has worked long, hard and skillfully to organize this meeting for us. The best way for each of us to show our appreciation is take advantage of the program to be presented.



President, Medical Association of Georgia

CHEST PHYSICIANS ESTABLISH RESIDENT LOAN FUND

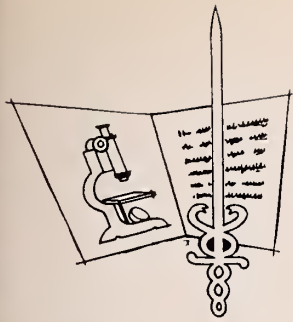
The American College of Chest Physicians has established a fund providing for loans to resident physicians to stimulate interest in postgraduate study of chest diseases and to assist postgraduate students in continuation of studies in diseases of the chest (including diseases of the heart and lungs).

Distribution of the funds is under the jurisdiction of the Committee on Resident Loan Fund of the College. Dr. M. Jay Flipse, Miami, is Chairman of the Committee. Other committee members are Dr. David A. Cooper, Philadelphia, and Dr. Philip H. Narodick,

Seattle.

Any physician who has completed an internship of one year or more in an acceptable hospital may apply for a loan to continue in the specialty of chest diseases. Loans are made only to physicians serving residencies in chest medicine and cannot be made to physicians engaged in practice.

Application forms may be secured by writing to the Committee on Resident Loan Fund, in care of the Executive Offices of the American College of Chest Physicians, 112 E. Chestnut Street, Chicago 11, Illinois.



NEOPLASMS AND "PRECANCEROUS" LESIONS OF THE ORAL REGIONS

Minor O. Turrentine, D.D.S., *Columbus*

THE TISSUES OF THE oral regions are susceptible to diseases caused by living organisms, chiefly bacteria, viruses and yeasts, by variations in genetic makeup, by disturbed metabolism, by injury from physical, chemical or radiant energy, by variations in the growth processes, and by some yet unmasked causes. Within this last group of diseases are the tumors, some benign, and others, the killers, malignant. The dentist has a responsibility in this area of health and disease which he dare not neglect. He must be aware of cancer, know how to diagnose it and be familiar enough with the methods of treatment and the outcome of treatment to advise his patients. He must be capable of aiding the cancer therapist and of assuming the major role in rehabilitation by prosthetic aid.

Nomenclature

There are a variety of benign and malignant neoplasms, with "precancerous" lesions and lesions which must be differentiated from them. Although the malignant tumors are much rarer than benign tumors and other lesions they cannot be considered rare, or in any sense unimportant.

The term "precancerous" holds different meanings for different people. To the bench pathologist it may mean only that the lesion shows dyskeratotic changes in microscopic section; to the clinician it may indicate that the lesion falls within a group of changes loosely associated with possible malignant growth; to the patient it may signify the doom of death. One cannot hope to change all this by discussion, but an unemotional review of the situation is in order. In part, because white plaques appear along borders of certain oral cancers, particularly on the buccal mucosa, it has been concluded that leukoplakia is a "precancerous" lesion. Whether the white lesion preceded the cancer or not is seldom established. It is true that on occasion leukoplakia is observed without clinically or microscopically demonstrable malignant change and that carcinoma develops later in the identical lesion, but

how much more frequent is that occurrence than the development of carcinoma directly in a normal-appearing region of oral mucosa? In raising this question there is no intention to belittle the fact that leukoplakia is a warning sign indicating activity of an irritating factor that may be carcinogenic.

Oral pathologists who place their emphasis on the morphologic picture, as seen in a microscopic section, have attempted to separate white, keratotic lesions of the mouth into those showing dyskeratosis and those showing only increased keratosis. To make this differentiation requires biopsy and histological examination, a procedure which many competent clinicians consider unnecessary if the history, clinical appearance and course are favorable and if the irritation can be eliminated and regression is observed. In how many white lesions of the mouth, clinically diagnosed as leukoplakia, as differentiated from lichen planus, cheek chewing, drug burns, and white sponge nevus, has carcinoma developed? Are we being over-zealous in our diagnoses and our use of the term "precancerous?"

Irritants

We must consider the potentiality of leukoplakia, whether we are using the term clinically as applied to keratotic white lesions or histologically as applied to dyskeratotic lesions. In either case irritants are active and the same irritation which causes epithelial cells to mature more rapidly (hyperkeratosis) or abnormally (dyskeratosis) may activate carcinoma if the tissue is susceptible to malignant change. For this reason, it appears that the most important procedure, wherever possible, is to eliminate the irritants. If no areas of redness are observed within the field of whiteness and if no induration, verrucous proliferations or ulcerations are present it is probably clinically sound to eliminate the irritant and keep the lesion under strict observation, and not resort to surgery unless adverse changes appear or the lesion progresses after removal of the irritation. In any but the mildest,

clinically hyperkeratotic lesions, biopsy is indicated. It is often advantageous to remove small lesions in toto and concurrently to eliminate irritants. The clinician must remain cautious, suspecting and alert but need not be stampeded into unnecessary surgery or into overstressing his patient.

Early discovery is essential. The dentist or physician must suspect possibility of neoplastic disease in any lesion he treats. He must complete his diagnosis in all cases or refer the patient to someone qualified to make the diagnosis. This does not mean

a mere suggestion to the patient to see his "doctor" but that a definite referral be made to a competent person, dentist or physician, with special knowledge of oral diseases.

Dental problems frequently force a patient, who gives a history of not having seen a physician in years, to consult his dentist. This presents the opportunity to reduce the unnecessary death toll from oral cancer by early diagnosis. His responsibilities continue as consultant to the surgeon or radiation therapist and as a principal in prosthetic reconstruction after necessarily destructive therapy.

Approved by Professional Education Committee, Georgia Division, ASC.

**MEDICAL ASSOCIATION
OF GEORGIA**

ANNUAL SESSION HEADQUARTERS

DeSoto Hotel

Savannah, Georgia

May 6-9, 1962





WHAT THE ECG CAN SHOW

Edgar Woody, Jr., M.D., *Atlanta*

SINCE THE FIRST SUCCESSFUL electrocardiographic tracing in a human was described by Einthoven in 1903, many ingenious refinements have been made in recording devices and multiple lead arrangements. With the great volume of clinical experience which has been accumulated within the past few years and with the widened research interest generated by the remarkable improvement in electronic recording equipment, the ECG has come to be recognized as a highly respected adjunct in the diagnosis and management of cardiac disease. Electrocardiography is now so much a part of standard medical practice that many physicians and laymen feel that no general medical examination is complete without a tracing.

In order to be of real value, an ECG must be recorded properly. Artifacts may result from many causes which need not be enumerated here. An ECG interpretation can be no better than the technical quality of the record from which it is made. By the same token such an interpretation can be no better than the technical skill and good judgment of the electrocardiographer. Simple clinical physiologic experiments employing exercise, carotid sinus stimulation, the administration of atropine or amyl nitrite may be required to alter the cardiac mechanism and add information which will permit a correct interpretation. Additional ECG observations after trial doses of digitalis, quinidine, procaine or other drugs may be required. It is the correlation of the ECG data with the other clinical and laboratory information which should be our aim.

Localization of Abnormalities

Significant abnormalities seen in ECG tracings include those situations where there may be abnormalities of conduction, abnormalities of the pump structure which includes the pericardial, myocardial, and the endocardial layers of the heart. Changes in certain body electrolytes may be reflected in the ECG pattern. Toxic levels of cardiac drugs, such as digitalis, quinidine and pronestyl

produce characteristic patterns. Such diseases as progressive muscular dystrophy produce electrical changes which should not be overlooked.

The ECG has rightfully been called the "Court of Final Appeal" in the diagnosis of disorders of the cardiac rhythm.

Among those defects in the actual pumping mechanism of the heart, characteristic tracings are recognized in most instances though by no means in all. It is in this area that serial tracings are of utmost importance.

Electrolytes

Low serum potassium levels present a fairly characteristic ECG tracing as do low serum calcium levels. Correlating the ECG with high serum potassium levels is much more difficult than with low levels. Often several electrolyte disturbances coexist; most commonly they are found in either acidosis or alkalosis. It has been known for many years that some enlarged hearts, particularly those with decompensated mitral lesions, readily develop extra systoles after small doses of digitalis. The potassium content of the myocardium in these cases has been found to be diminished. It is important to remember that extra systoles are not primarily a sign of digitalis intoxication but rather are the consequence of the action of digitalis on a heart with diminished potassium content. A similar mechanism is responsible for a great variety of cardiac arrhythmias seen during exhibition of digitalis.

The T wave is the most labile segment of the ECG and may be grossly altered, not only in the presence of organic heart disease but in its absence. The latter possibility must be kept in mind in order to avoid a diagnosis of heart disease where none is present. In infants and children, T waves may be normally inverted in leads V1 to V4 or V5. Evolution to the adult form may be delayed in some individuals until relatively late maturity. This tendency persists longer in women than in men and is particularly true in negroes where the juvenile pattern is often seen in adults. Occasional isolated

HEART PAGE / Continued

T wave inversion may occur in a normal heart in leads V4, V5 or V6. These changes are thought to be due to increased vagal stimulation and may frequently become upright following the administration of atropine. Other conditions which may alter T wave normality are infections, fever, pain, fear, shock, temperature change, smoking, and the administration of digitalis or quinidine. Varying degrees of vagotonia, as following a meal, may increase the PR interval to abnormal levels with subsequent reversion to normal. To rule out a functional A-V block, the administration of atropine is useful. Conversely, normal A-V conduction is often found in active rheumatic carditis. The fortuitous freedom from Aschoff bodies along the A-V conduction system is a reasonable explanation for this phenomenon. Abnormalities of QRS conduction are perhaps more common than A-V block. Frequently right bundle branch block may occur in the total absence of otherwise demonstrable

heart disease. Left BBB is generally a manifestation of coronary artery disease, important myocarditis, or left ventricular hypertrophy. Extensive ST elevations may be seen normally in the inner precordial leads. Similarly, ST depressions are encountered when the T wave is normally inverted as in lead AVR. Measurable depressions of even less than one millimeter in other leads, however, may be abnormal and generally indicate a digitalis effect or myocardial hypoxia.

A recent epidemiological study in Framingham, Massachusetts, has beautifully demonstrated the fallibility of using the ECG alone as a screening instrument for the detection of cardiac disease. Fifty-three per cent of those with definite heart disease and 64 per cent of those with possible heart disease had normal ECGs.

Thus the ECG is most valuable when its limitations are kept in mind. It should never precede, and can never replace a thorough history, a careful physical examination and good clinical judgment.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

MEDICAL ASSISTANCE TO THE AGED PROGRAM FUNCTIONING IN GEORGIA

The Medical Assistance to the Aged Program has been in effect for two complete months. It is much too early to predict certain aspects of the program.

The forms show the total number of days hospitalized and, therefore, with more experience, this should indicate expansion or contraction of the program.

However, certain tendencies may be projected from experiences at the present time. The cost of both the hospital and nursing home program for the month of January was \$186,141.40. The cost of the hospital program was \$12,496.42. There were 109 hospital patients approved compared to 1,096 in nursing homes. The reason for this wide variation is very simple. Almost all of the recipients were in nursing homes before inception of the program and were merely transferred directly to the OAA Program as a paper transfer.

When the program has reached its maximum, it is estimated that the monthly cost will be approximately \$600,000.00. The total cost of the first month would represent about 28 per cent of this estimated maximum. This is an excellent start considering the rapidity with which the program was organized.

Although it is not safe to estimate the final volume

and cost on so short a period, it may be said that the mechanics of the program are basically sound. The claims, when properly completed, carry adequate information for classification. Also, the majority of the hospitals in the State have qualified under the rules and regulations set up by the Welfare Department. The major difficulties have occurred in the areas of misunderstandings as to the limitations of the program. Only those acutely ill or exacerbation of chronic conditions requiring hospitalization for treatment are eligible for payment. This situation, however, is rapidly rectifying itself in that the number of claims which have to be returned for additional information are diminishing.

In summary, it may be said that the OAA Program is a good program, meeting the needs of the most needy of our elderly citizens. The team consisting of the doctors of Georgia and the Welfare Department is rapidly bringing to Georgia the best possible medical service under the OAA Program. I wish to thank the doctors and hospitals of Georgia for their understanding and cooperation in getting this program off the ground.

John T. Mauldin, Medical Director, OAA



PARENTAL CONTRIBUTIONS TO CHILDHOOD EMOTIONAL DISTURBANCES

Alfred Agrin, M.D., *Atlanta*

CHILDREN SEEM TO BE born with different capacities or levels of aggression, of "life-force" or "push" or whatever word one wishes to give to this capacity to assert one's self, make a place for one's self, test out the members of one's environment. Depending upon the amount of this "life-force" within the child will depend the amount of conflict which this child will arouse in his family. These conflicts can be thought of as differences of opinion between the child and his parents, but, of course, adults rarely see it that way. Adults usually speak of it as obstinacy or contrariness when a child has a different opinion from theirs, and particularly when the child is very anxious to have his own way at all costs. But conflicts between people who live in close proximity to each other and are dependent upon each other, arouse so much discomfort that they must be resolved. Otherwise, the tensions become too great.

There are three general means by which most parents try to resolve these conflicts which arise over differences of opinions.

Domination of the child

The parents make it quite clear by word and action that they are bigger, stronger, wiser and amply able to enforce their side of the conflict. This is frequently a highly satisfying solution for the parent and a highly unsatisfying solution for the child. Temporarily, the parent wins, the child loses. For children with a good deal of strength, this becomes a challenge for future combats, perhaps in different ways. For children with less "life force," being continuously dominated by one's parents serves as a continued reminder of their own inadequacy and whatever strengths they have are utilized mainly in attempting to prove their inadequacy and thereby making other stronger people take responsibility for them.

Submission to the child

By this I am attempting to describe the kind of

situation in which the parent habitually submits to the will of the child in most matters of differences of opinion. This is temporarily a highly satisfying solution for the child, and a highly unsatisfactory one for the parents. The child wins, the parent loses. However, not only does this arouse intense resentment in the parent toward the particular child to whom they are forever giving in, but it also arouses great anxiety in children.

Children base most of their ideas about what they themselves will become upon what they see in their parents. If their parents are anxious and yielding, there will be little incentive for they themselves to grow up and become adults because, to them, adults are yielders and losers. The "strong-willed" child becomes unruly and undisciplined. Severe phobias are not uncommon and fear of going to school is often quite characteristic. The "weak-willed" will often present the picture of the so-called "schizoid" person.

Compromise with the child

This is the kind of situation in which the parents are constantly attempting to make compromises with the child and constantly expecting the child to make compromises with them. Strangely enough, this is not usually satisfying to either parent or child. In fact, both sides usually have the feeling of having lost the struggle, and neither ever has a real sense of winning in anything. The conflicts continue, but there is so much emphasis on the need to "give a little" that the conflicts are rarely apparent, tempers are always even, struggles never arise, but deep hostile feelings exist, strong dependency feelings are never fully satisfied, the idea of being angry is simply not tolerated. Many people with psychosomatic symptoms in adulthood give a history of this kind of childhood relationships with their parents. From these logical, thoughtful, even-tempered, "compromising" parents frequently come severe problems in their children. Frequently extremely excessive demands are made by both the

MENTAL HEALTH / Continued

parents and the child upon each other, because each knows that there will have to be some compromise and excessive demands are made in order that as little will be lost as possible in the process of trying to resolve the conflicts.

Each of these methods represent, in the main, the parents' part in the development of the emotional disturbances in their child. When we gain a fairly accurate idea of the quantity and direction of "life-force" in the child and an idea of the most common means by which the parents try to resolve the conflicts which arise, we usually have a good understanding of the kind of symptoms we see in the child. This sometimes becomes very complicated, however, when we find couples who are in conflict within themselves and utilize much the same mechanisms to solve the conflicts within themselves as they try to do with their children. For example, we may have a domineering mother and a submissive father, or the reverse. Or we may have a domineering mother and a compromising father. Other combinations can be easily visualized.

With effective psychotherapy with the child and his parents, we can see an alteration in these patterns and a lessening of the child's symptoms. The "life-force" of the child actually seems to increase, but it is directed into other and more constructive channels than the arousal of struggle and

conflict. Concomitantly, we see a shift in the parents' accustomed ways of trying to resolve the struggle and conflicts, away from the domination or submission or compromise and more towards an integration of the differences, a search for means by which both parents and child can have a sense of satisfaction. Neither feels beaten by the other, even to the slightest extent. At first this comes very hard to parents, they feel strained, find themselves "missing the boat" more often than not, but after a while it can come easily and naturally. It is equally difficult for the child to relinquish old patterns of demands and struggles. During psychotherapy and for some time after it, one can observe the child quite obviously in a maturing process. The child clings to old, struggling, disorganized patterns of behavior, at the same time straining for more organization, more integration with the family and friends, more thoughtfulness and less panic-stricken, anxiety-ridden activity.

In summary, the problems with which child psychiatry deals are the product of the interplay between the born-with characteristics of the child as they come into dynamic relationship with the characteristic modes of reaction to conflict of the parents. Successful resolution of childhood psychiatric problems depends frequently upon the clarity with which the physician can see these interplays and the willingness of parents and child to submit themselves to an examination and a reorganization of old struggles and conflicts.

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

THE 1962 ANNUAL AMA MEETING

Each year at this season it is customary for the president of the American Medical Association to extend an invitation to all American physicians to attend the AMA's annual meeting. Each year it is also expected of the president to state that "this year's meeting will be the best yet."

This year I have no hesitation in proclaiming that the 1962 Annual Meeting June 24-28 at Chicago will be an excellent scientific session that will offer much solid, comprehensive information that will be of great value to those of us in the practice of medicine.

Dr. Samuel P. Newman, chairman of the Council on Scientific Assembly, and his colleagues, together with the Council's new secretary, Dr. George R. Meneely, has done a splendid job in studying the entire field of medicine and determining in which area there has been substantial progress worth reporting to the men in practice.

As usual, the program for the meeting is scheduled for publication May 19 in the Journal of the AMA. You will be able to judge for yourself whether I am right in saying that the program for the 1962 meeting is the finest ever assembled for the benefit of the

American medical practitioner.

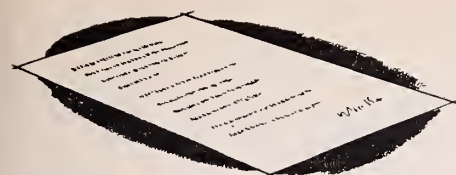
Theme of the meeting will be "Medicine in the Atomic Age." This is a broad, generalized theme that covers everything in medicine. And that is just what the scientific program will do.

The 21 sections concentrating on the medical specialties are pooling their talents and resources to bring the top men in the nation to deliver papers in areas such as Nuclear Medicine, Mental Health, Tissue Transplantation, Inflammatory and Ulcerative Diseases of the Small Intestine, Inhalation Therapy, Clinical Cardiology and Anticoagulant Therapy, and Diagnostic Problems and Exfoliative Cytologic Methods.

And for those of you who swore "never again!" following the last Annual Meeting in Chicago in 1956, allow me to point out that the 1962 meeting will be in the swank new McCormick Place, completely air conditioned. The steamy heat and cramped quarters of the old Navy Pier are just an unpleasant memory.

See you in June in Chicago!

*Leonard Larson, M.D.,
President, A.M.A.*



ABSTRACTS BY GEORGIA AUTHORS

Zuspan, Frederick P., M.D., and John D. Bell, M.D., Medical College of Georgia, Augusta, Georgia, "Variable Salt-Loading During Pregnancy with Preeclampsia," *Obst. & Gynec.* 18:530-534 (Nov.) 61.

Recent publications in the English Literature have questioned the time honored dictum that the pregnant patient should be on a low salt diet. This study was undertaken to evaluate the controlled effects of known salt-loading diets of normal, mild and moderate preeclamptic patients. Balance ward studies were done under controlled salt intakes. The time on the balance ward varied from five to 14 days. The salt intake varied from one to 5.5 grams per day for normal controls, normal controls with salt-loading, mildly preeclamptic patients with salt-loading, and mildly preeclamptic patients with no salt-loading. The electrolyte excretion pattern of these various groups of patients were compared as well as their urinary output, weight loss, and clinical status.

An increase in salt-loading caused a different balance ward excretion pattern. The excretion pattern of salt-loaded controls and of salt-loaded mild preeclamptic patients were essentially similar. If the pattern of the moderate preeclamptic patients is compared with the mild preeclamptics in the salt-loaded controls, a marked difference was seen. Apparently, the degree of salt retention in the toxemic patient dictates to some extent the response to added salt. A diuretic medication in the salt-loaded moderately preeclamptic patient changed the excretion pattern to less sodium retention and excess of intake at this salt-loading level. The excessive intake of salt is detrimental to the moderately preeclamptic patient.

Bartholomew, R. A., M.D., 272 Boulevard, N.E., Atlanta 12, Georgia, "Hemorrhages of Late Pregnancy," *Postgrad. Med.* 30:397-406 (Nov.) 61.

Rupture of the marginal sinus is, by far, the most frequent cause of concealed as well as external hemorrhage during pregnancy. This conclusion has been reached by examination of innumerable placentae over many years. As stated in the article, an understanding of the placental circulation is fundamental to an understanding of the mechanism of marginal sinus bleeding, but must be omitted here; likewise, statistical data on bleeding due to failure of development.

The marginal sinus is formed early in the first trimester but until it is reinforced by the expansion and weight of the amniotic sac, it is very subject to breakthrough. In the second trimester bleeding is sharply reduced. With greater adherence of the membranes, blood escaping from the site of sinus rupture tends to collect at the adjoining placental margin, raising the membranes and overlaying the rim of the

placenta (circumvallate) or extravasating along the margin (marginata). Irritation from the clots or repeated ruptures often lead to abortion or premature labor.

In the third trimester, due to increasing Braxton Hicks contractions, the upward pull on the lower uterine segment causes tension on the marginal sinus, especially so if the placenta is low-lying. Bleeding at this stage is much greater and often results in premature labor. A thrombus can usually be demonstrated connecting the torn sinus to the clot.

There is strong reason and evidence that the bleeding of low-lying, marginal or partial placenta previa is, in reality, that of marginal sinus bleeding. In total placenta previa, tension and stretch is on the placenta itself, and not on the sinus. The previal area is a vacuum in respect to blood pressure and favors downward bleeding through the previal area.

Humphries, A. L., Jr., M.D.; W. S. Harms, Ph.D., and W. H. Moretz, M.D., Medical College of Georgia, Augusta, Georgia, "Skin Homografts in Dogs Deficient in Pyridoxine," *J.A.M.A.* 178:490-492 (Nov.) 61.

A simple and very satisfactory method for grafting ear skin is described. Dogs acutely deficient in pyridoxine (vitamin B₆) did not tolerate skin homografts significantly longer than control dogs did. Eleven dogs made chronically deficient did tolerate skin homografts longer than did the control dogs, an average of 17.2 days as compared with 8.8 days. In this chronically deficient group, the six dogs that tolerated skin homografts for an average of 22.6 days showed lower lymphocyte counts 12 days after being grafted than did the other five, who rejected homografts in an average of 9.6 days. The alpha-1, alpha-2, beta-1, beta-2, and gamma globulin concentrations in the deficient dogs did not change consistently, and in the control dogs remained strikingly unchanged after grafting.

Brown, William J., M.D., Venereal Disease Branch, Communicable Disease Center, Public Health Service, Atlanta, Georgia, "Cluster Testing—A New Development in Syphilis Case Finding," *American Journal of Public Health*, 51:1043-1048 (July) 61.

Time has long been considered a vital factor in controlling venereal disease, and new methods are always being sought to shorten the amount of time elapsing between infection of an individual and his treatment, with the object of reducing as far as possible the number of opportunities for the disease to be transmitted to additional persons.

One of the methods of case finding is contact tracing. Infected patients are asked to name those persons to whom they were exposed sexually since the beginning of the incubation period.

"Cluster testing" extends contact tracing to include examination of two other groups: "suspects" and "associates." A "suspect" is anyone other than a sex contact who the patient thinks might need a blood test. An "associate" may be a friend or social acquaintance who is named by or is found in the company of sex contacts or "suspects."

In describing the technique of "cluster testing" the author discusses how cases of syphilis can be found indirectly by clustering that would be missed by contact tracing alone.

Wigh, Russell, M.D.; William F. Lindsey, M.D.; Jack Morgan, B.S.; and Winford H. Pool, Jr., M.D., Medical College of Georgia, Augusta, Georgia, "A Patient Propulsion Procedure for Aorto-Arteriography," *Radiology* 77:813-823 (Nov) 61.

A radiological method for visualization of the abdominal aorta and its pelvic and lower extremity branches is discussed. The patient is placed prone on a table which is driven by a small motor over the film recording area of a serialographic film changer. Forty cc. of contrast agent is injected into the abdominal aorta below the level of the renal arteries. The patient is moved cephalad at a rate of two inches per second. A film is exposed every three seconds until the ankle area is reached. At this time, the movement is reversed. An injection time of ten seconds is employed. Patient propulsion is not begun until five seconds have elapsed. This partially assures that the table speed does not outstrip the column of contrast agent.

The procedure allows opportunities to study the arterial system from the region just below the renal arteries to the ankles. Reverse propulsion provides an opportunity to visualize very delayed filling of the vascular bed. This type examination presents a study not only of anatomic abnormalities but of pathophysiological changes.

Morgan, Jack M., B.S. and Russell Wigh, M.D., Medical College of Georgia, Augusta, Georgia "Isointensity Patterns of Scattered Radiation Around a Mirror Optic Photo-fluorographic Unit" *Am. J. Roentgenol.* 86:983-985 (Nov.) 61.

With the development in the last few years of the much faster mirror optic cameras for photofluorographic procedures, exposure dosages to patients have been reduced. These newer cameras also play an important role in the protection of technical personnel.

Measurements made around a modern chest photofluorographic roentgen-ray installation utilizing a mirror optic system indicate less scattered radiation compared with that from lens type photofluorographic cameras. A diagram shows a typical installation of a mirror optic type camera with its field pattern of scattered radiation.



THE ASSOCIATION

DEATHS

PAUL LOVEJOY HUDSON, Atlanta, died February 11, 1962 at the age of 70. He was a graduate of the University of Georgia and Columbia University and did graduate work at the Mayo Clinic.

Dr. Hudson taught physiology and surgery at Emory University at one time. He served in World War I and World War II. He was a member of the Fulton County Medical Society, the American Medical Association, the Medical Association of Georgia, and the Southern Medical Association.

He is survived by his wife, Marian Steward Hudson; two daughters, Millie and Kathleen Hudson; one son, Paul L. Hudson, Jr.; two sisters, Mrs. J. Ross Garner, Atlanta and Mrs. Griffin Roberts, Canton; and a brother, Henry Hudson, Asheville, N. C.

AVARY DIMMOCK, SR., 68, died at his home in Atlanta on March 1, 1962. He had served for many years as associate professor of clinical medicine on the Emory University Medical School faculty.

Dr. Dimmock was a graduate of the University of Georgia and Emory University School of Medicine. He was a member of the American Medical Association, the Medical Association of Georgia, the Georgia Heart Association and served as vice president of the Fulton County Medical Society in 1933. He was chief of the medical staff of the Atlanta Tubercular Association three years and worked with that association for nearly 15 years. He was a member of the Druid Hills Presbyterian Church and the Masons.

Dr. Dimmock is survived by his wife, Alice Reed Dimmock, a daughter, Mrs. Luke W. Wesson, Albany, N. Y.; a son, Avary Dimmock, Jr., Ellijay; and a step-daughter, Mrs. Edward L. Chandler, Atlanta.

PERSONALS

First District

MASON G. ROBERTSON and MURRAY C. ARKIN of Savannah and SAMUEL P. TILLMAN of Statesboro were recently certified by the American Board of Internal Medicine.

ROBERT W. OLIVER, JR. of Lyons was recently awarded the Distinguished Service Award by the Lyons Junior Chamber of Commerce.

MEYER M. SCHNEIDER of Savannah was elected as president of the staff of St. Joseph's Hospital during February. Serving with him are ANDRO P. PHILLIPS as vice president and ALLEN W. COWART as secretary.

WILLIAM G. SIMMONS of Sylvania received orders that called him to active duty by the U.S. Air Force, for a period of two weeks during February.

THE FIRST DISTRICT MEDICAL SOCIETY held its annual meeting in February in Statesboro, at the Forest Heights Country Club. The program was directed by CHARLES EMORY BOHLER of Brooklet and CLAUDE STARR WRIGHT of Augusta.

Second District

C. L. HOWARD of Pelham recently attended the postgraduate course, "Cardiac Emergencies" at the Medical College of Georgia in Augusta.

Third District

CLARENCE C. BUTLER of Columbus spoke in February to the Lumpkin Parent-Teacher Association. He discussed heart disease in children.

Fourth District

It was announced in March that ROBERT L. BENNETT of Warm Springs was selected as the Horowitz Visiting Professor for 1962.

Fifth District

P. THOMAS MANCHESTER, JR. of Atlanta recently opened his new office at the Doctors Building. His practice is limited to ophthalmology.

MILTON T. EDGERTON, SR., of Atlanta was recently honored with a 50-year commemorative medalion, presented to him by Dr. Milton S. Eisenhower, president of Johns Hopkins University.

J. FRANK WALKER of Atlanta was made a fellow of the American College of Radiology at their recent meeting in New York City.

PAUL TURRENTINE of Atlanta and state president of the Exchange Club, recently spoke to the Jackson Club in Jackson about the disastrous results of conformity.

JOHN R. LEWIS, JR., of Atlanta was named Writer of the Month at the February meeting of the Atlanta Writers' Club.

J. WILLIS HURST of Atlanta spoke in February at a Sunday night service at the Presbyterian Church in Carrollton.

MORGAN B. RAIFORD of Atlanta recently had the second printing of his book, "Contact Lens Management," put on the market. Plans are being made to publish a Spanish edition.

TED F. LEIGH of Atlanta who was recently named Chairman of the Commission on Public Relations of the American College of Radiology, spoke at the March meeting of the Philadelphia Roentgen Ray Society in Philadelphia, Pennsylvania. His subject was "Mass Lesions of the Posterior Mediastinum."

CHENEY C. SIGMAN, JR., Atlanta, has limited his practice to allergy as of March.

BRUCE LOGUE of Atlanta was recently guest lecturer at the meetings of the Memphis Heart Association in Memphis, Tennessee. Also his recent travels have

taken him to Tuskegee, Alabama, where he lectured at the Veterans Administration Hospital.

Sixth District

EDWIN W. ALLEN, JR. and CHARLES B. FULGHUM of Milledgeville recently attended the postgraduate course, "Cardiac Emergencies" at the Medical College of Georgia in Augusta.

FOLKE BECKER of Dublin who was chief of Physical Medicine and Rehabilitation Service at the Dublin VA Center has been transferred to the same post at the VA Hospital in Birmingham, Alabama.

Seventh District

TRAMMELL STARR of Dalton was recently honored with a 50-year commemorative medallion which was presented to him in Atlanta by Dr. Milton S. Eisenhower, president of Johns Hopkins University.

L. G. FORTSON, JR., G. T. MIMS and A. H. RANDALL of Marietta were notified in February of their certification by the American Board of Internal Medicine.

PAUL FITZPATRICK, CECIL F. JACOBS and L. C. YEARGIN of Dalton recently attended the postgraduate course "Cardiac Emergencies" at the Medical College of Georgia in Augusta.

Eighth District

HORACE LEE MORGAN of Baxley and CLYDE V. TANNER of Pearson recently attended the postgraduate course, "Cardiac Emergencies" at the Medical College of Georgia in Augusta.

RICHARD L. BENSON of Broxton has recently assumed the duties of radiologist at the Irwin County Hospital.

Ninth District

The TOCCOA CLINIC held their annual Toccoa Clinic Medical Science Day in March. The guest speakers were Dr. George Hamil, Chief of the Radioisotope Section at Maxwell Air Force Base Hospital and Radiologic Consultant to Project Mercury and Dr. Fred Stowe, Chief of Pediatrics at the same hospital.

W. W. HARRIS of Royston, SAMUEL H. HAY of Toccoa, OLAND GARRISON of Demorest, and BARTLEY WILBANKS of Clarksville attended the postgraduate course "Cardiac Emergencies" at the Medical College of Georgia in Augusta recently.

CLAUDE E. BENNETT of Toccoa was recently promoted to Lieutenant-Colonel in the Georgia National Guard.

Tenth District

HENRY M. ALTHISAR of Thomason and J. W. WILLIAMS of Lavonia were appointed to the State Board of Medical Examiners in February by Governor Ernest Vandiver.

LOUIS G. CACCHIOLI of Hartwell recently attended the postgraduate course "Cardiac Emergencies" at the Medical College of Georgia in Augusta.

CAROL G. PRYOR of Augusta was one of about ten women physicians in the United States honored by the American Medical Women's Association as Medical Woman of the Year at their recent National Meeting in Cleveland, Ohio.

SOCIETIES

BALDWIN COUNTY MEDICAL SOCIETY was addressed in Milledgeville during February by Dr. Tom Williams of Macon, on "Vascular Surgery."

BIBB COUNTY MEDICAL SOCIETY recently sponsored a series of tapes entitled "Medical Milestones" on the Macon station WMAZ.

CARROLL - DOUGLAS - HARALSON MEDICAL SOCIETY's members heard Dr. P. C. Astin, Jr., speak in February in Douglas County on several cases he encountered as medical examiner of Carroll County.

CHEROKEE-PICKENS MEDICAL SOCIETY met in Canton during February and elected their 1962 officers. They are: Arthur Hendrix, President; Bill Nichols, vice president; and John Cauble, secretary.

DOUGHERTY COUNTY MEDICAL SOCIETY was host recently at a dinner in Albany. Guests were the Dougherty County Dental Society and the Dougherty County Pharmaceutical Association. The program centered around proposed congressional legislation affecting medical care.

FULTON COUNTY MEDICAL SOCIETY recently sponsored a four-day Atlanta Graduate Medical Assembly in Atlanta and featured several outstanding speakers from across the United States.

The GEORGIA MEDICAL SOCIETY held their regular monthly meeting in Savannah during March. Dr. Victor Vaughan, Professor of Pediatrics, Medical College of Georgia, spoke on "Genetics and Genetic Counseling."

OCONEE VALLEY MEDICAL SOCIETY met in Greensboro in February to hear Dr. Henry Cabaniss, dermatologist from Athens speak on allergic skin conditions.

SPALDING COUNTY MEDICAL SOCIETY met in February in the hospital conference room in Griffin. Dr. Alex Jones presented an outline of the Disaster Committee work on a Disaster Plan for the Griffin-Spalding County Hospital and the medical staff.

RICHMOND COUNTY MEDICAL SOCIETY and the Augusta Dental Society met during February in Augusta. Col. Robert B. Shira, chief of oral surgery and head of dental services at Walter Reed Hospital in Washington, D. C. spoke on "Diagnosis of Oral Lesions."

FRANK VINSON of Fort Valley recently attended the postgraduate course "Cardiac Emergencies" at the Medical College of Georgia in Augusta.

MINUTES OF SUB-COMMITTEE ON SCHOOL CHILD HEALTH

THE FALL MEETING of the Sub-Committee on School Child Health was held on Thursday, December 14, 1961 at 7:00 P.M. at MAG Headquarters Building in Atlanta.

Those sub-committee members present were Chairman John Bowen, Sandy Springs; J. C. Hughston, Columbus; William Bonner, Athens; and Virginia McNamara, Atlanta. Also present was Dr. Judson Hawk of Atlanta and Mr. James M. Moffett of the MAG Headquarters Staff.

Following a dinner, Chairman Bowen called the meeting to order and gave a few opening remarks of welcome.

School Health Program

Dr. Bowen gave a few general remarks on this matter. Dr. Virginia McNamara, Director of the School Health Service, Georgia Department of Public Health, presented to the group a request from Dr. Mamie Jo Jones, Director of the Program for Exceptional Children, State Department of Education. Dr. Jones requested that the local medical societies be

asked if some of the physician membership would be willing to assume the responsibility for physical examinations including specialty examinations as indicated, for medically indigent children who are candidates for classes in special education (mentally retarded, physically handicapped, emotionally disturbed, etc.). Each child, before being placed in a special education class, must have a complete physical examination plus other diagnostic studies by specialists as indicated.

The medical director of the local public health department will, upon request of the school, contact those physicians in their local medical societies indicating their willingness to give services to the children in low income families whose expenses are not covered by any of the services presently available in Georgia through the departments of welfare and public health and community agencies.

It was the feeling of the group that the physicians in private practice would be glad to give this service to the community when requested to do so. It was further suggested that if a long list of physicians willing to serve be made available to the public health medical officer by the secretary of the local medical society, it would tend to offset the current practice of burdening one or two physicians in a community with the entire case load of the exceptional children.

The recommendation was made that this information be published in the MAG Journal in an effort to familiarize physicians with the fact that there is a large group of children, candidates for special education classes, whose needs can be met through better understanding of the current situation, as expressed in the request from Dr. Mamie Jo Jones. She also reported that the Health Department was discouraging mass physical examinations.

During the general discussion that followed, Dr. Hughston pointed out that the same children are being seen by physicians too often and that others are not being examined enough. Dr. McNamara pointed out that children had to have a classified defect in order to receive treatment at one of the children's clinics.

Following this discussion the sub-committee then voted to recommend that mass physical examinations be abandoned. The sub-committee further recommended that a physical examination and a certificate attesting to such examination be required of all entering first grade students and that subsequent to this that school teachers refer students in need of special examination by: (1) advising parents of child, (2) such child then seen by private practitioner, (3) if a private practitioner who is a member of a roster of doctors established in advance of such examinations.

School Fallout Program

The need for a comprehensive program to put into effect in the event of nuclear attack was discussed by members of the sub-committee. Reference was made to a recent drill carried out in the public schools at Sandy Springs, Georgia. Dr. Bonner expressed concern over the number of accidents which may occur among school children in the event of a real attack if we do not develop a workable plan. Dr. Bowen asked Dr. McNamara to establish liaison with Dr. Dunstan, Chairman of the Disaster Medical Care Committee, for the purpose of conveying the interest of the School Child Health Sub-Committee in this program.

Medical Aspects of Sports Conference

Dr. Hughston gave a report on his participation in the AMA Conference on the Medical Aspects of Sports held in Denver, Colorado in November, 1961. This report was received for information. In discussing the MAG Sports Injury Conference, Dr. Hughston told the sub-committee that he is considering a plan whereby he would invite high school team physicians and ask them to bring their respective coaches. By using this system, the Conference could avoid attracting the same people every year thus missing many who would benefit from this Conference. He pointed out that such a list of team physicians could be obtained from the local high school Coaches Association. He pointed out that the Conference should be held to about 200 participants each year. The Sub-Committee then voted to endorse Dr. Hughston's recommendation to invite team physicians and commended him for the fine job he was

doing with the Sports Injury Conference. The Sub-Committee voted to recommend that Dr. Hughston continue to serve as Chairman of this activity and that Dr. R. A. Dodelin be appointed to serve as Co-Chairman. It was recommended that Dr. Bowen write Dr. Dodelin to this effect.

Dr. Hughston pointed out that the best time to hold this Conference is in middle August and that it should be held at approximately the same time each year. He then concluded his report with a brief discussion of new equipment for high school athletics.

Indigent Children

Dr. Bowen gave a report on the care of indigent children by making reference to the Health Indigent Care law now on the statute books of Georgia. He brought this matter to the attention of the Sub-Committee for information and told the members that while a lack of funds prevented implementation of this law at this time that it should be watched closely as it will be of considerable value to the Sub-Committee when it is put into effect.

Diagnostic and Evaluation Centers for Handicapped Children

Dr. McNamara advised the Sub-Committee that the Health Department had formed a committee to study and determine if a need exist for diagnostic centers in the state where handicapped children could get a comprehensive "work up." She reported that the Committee is still in the formative stage. This report was received for information.

New Business

Mr. Moffett gave a brief financial report, pointing out that the Sub-Committee still had approximately \$630 prior to this meeting left in its funds allocated by MAG for the year 1961. He also advised the Sub-Committee that the Council had approved a budget of \$1,650 for the 1962 year.

Dr. Bowen raised the question of the need for a publication outlining the scope of services for handicapped children in all parts of the State. The Sub-Committee recommended that all County Medical Societies be written and asked to furnish the School Child Health Sub-Committee a list of available diagnostic services in their county or counties. Dr. Hughston pointed out that he thinks there might be money available in the Health Department for the publishing of this information once such is compiled.

Adjournment

There being no further business before this Sub-Committee, Chairman Bowen adjourned the meeting at 11:20 P.M.

MAG SUB-COMMITTEE ON REHABILITATION

THE MEETING OF THE MAG Sub-Committee on Rehabilitation was called to order at 10:00 A.M., February 11, 1962 by Chairman Robert L. Bennett.

Members of the Sub-Committee present were Robert L. Bennett, Warm Springs; F. James Funk, Atlanta; John B. O'Neal, Elberton; Vernon E. Powell, Atlanta and Thomas P. Goodwyn, Atlanta. Also attending the meeting was Mr. James M. Moffett, MAG staff member.

Physical Therapy Bill

Dr. Bennett gave the Sub-Committee background information on the existing Physical Therapy Act (Act of 1951) and discussed reasons why the physical therapists are making their current effort to enact new legislation which would give them their own State Board.

Dr. Bennett and Mr. Moffett discussed and explained certain features in the proposed Physical Therapy Practice Act. Mr. Moffett explained that the bill introduced by Representative Mac Barber was no longer under consideration, but that the House Committee on Hygiene and Sanitation had rewritten the bill completely and that certain features in the bill were there due to the presence of a chiropractor on the Hygiene and Sanitation Committee.

On motion duly made and seconded the Sub-Committee voted to go on record disapproving the 1962 proposed physical therapy bill and to further record themselves as being in support of the existing act (1951 Act) as related to the physical therapist. It further expressed itself to wit: that until a bill is

approved by the Sub-Committee that the State should retain the 1951 Act, and in addition wished to be recorded that they are eager to work with the physical therapist to develop legislation consistent with the highest educational and ethical aspirations of the physical therapist.

Vocational Rehabilitation Center

Dr. Bennett explained the purpose of this meeting with a full description of the proposed rehabilitation project under consideration by the Georgia Division of Vocational Rehabilitation. This facility is to be built adjacent to the Warm Springs Foundation. Dr. Bennett explained that Executive Committee of Council had requested an expression of approval or disapproval by the Sub-Committee on this matter. General discussion followed in which this project and alternatives were explored. The Sub-Committee then voted unanimously to endorse this project as it meets an unmet need in Georgia and it further recommended that MAG go on record as being in favor of this project.

EXECUTIVE COMMITTEE OF COUNCIL

THE REGULAR MONTHLY MEETING of the Executive Committee of Council was called to order by Chairman Fred H. Simon-ton at 2:00 P.M., at the MAG Headquarters Building, Atlanta, February 18, 1962.

Members attending were Fred H. Simon-ton, Chickamauga; George H. Alexander, Forsyth; John T. Mauldin, Atlanta; J. G. McDaniel, Atlanta; Thomas W. Goodwin, Augusta; Linton H. Bishop, Atlanta; and John S. Atwater, Atlanta. Also present were David R. Thomas, Augusta, Reverend Paul McCleave, Chicago and Mr. Richard Nelson, AMA, Chicago. Staff members present were Mr. Milton Krueger, Mr. James M. Moffett and Mrs. Catherine Wooten.

On motion (Goodwin-Alexander) it was voted to dispense with the reading of the minutes of the last meeting, as they had been mailed to the members.

AMA Blue Shield Aged Care Plan

Dr. David R. Thomas discussed the AMA Blue Shield Aged Care Plan and Dr. Mauldin, Dr. Goodwin and Mr. Krueger gave further information. It was also announced that a South-east regional meeting of state medical association officers and Blue Shield plan personnel would be held February 25, Hilton Inn, Atlanta. Chairman Simon-ton designated David R. Thomas, J. G. McDaniel, John T. Mauldin and Mr. Krueger to attend. The Executive Secretary was asked to notify Dr. Russell Carson, District Director, National Association of Blue Shield, and those designated to attend by the Chairman.

Proposed Vocational Rehabilitation Center, Warm Springs

Mr. Moffett read the minutes of the Sub-Committee on Rehabilitation meeting held February 11, 1962 as follows:

Vocational Rehabilitation Center

Dr. Bennett explained the purpose of this meeting with a full description of the proposed rehabilitation project under consideration by the Georgia Division of Vocational Rehabilitation. This facility is to be built adjacent to the Warm Springs Foundation. Dr. Bennett explained that Executive Committee of Council had requested an expression of approval or disapproval by the Sub-Committee on this matter. General discussion followed in which this project and alternative were explored. The Sub-Committee then voted unanimously to endorse this project as it meets an unmet need in Georgia and it further recommended that MAG go on record as being in favor of this project."

On motion (Alexander-McDaniel) it was voted to endorse the recommendations of the Sub-Committee on Rehabilitation approving the proposed Vocational Rehabilitation Center at Warm Springs.

Treasurer's Report

Dr. Atwater gave the treasurer's report and on motion (Mauldin-McDaniel) it was voted to approve the report as given.

Ad Valorem Taxes

Dr. McDaniel gave a report on the ad valorem tax status and this report was received as information.

Designation of Delegates to Alabama State Medical Association Annual Meeting

On motion (McDaniel-Mauldin) it was voted to ask the President to appoint the delegates to the Alabama Medical Association Annual Meeting. President Simon-ton then designated W. Steve Worthy, Carrollton, and Simone Brocato, Columbus, as delegates from MAG.

AMA Institute on Nursing Home Administration

Secretary Mauldin read a letter from Dr. Blasingame of the AMA regarding an institute on Nursing Home Administration to be held March 27-29, 1962, in Miami Beach. Dr. Atwater recommended that a representative attend this meeting, however, after discussion and on motion (Goodwin-McDaniel) it was voted that no funds be expended for attendance at this meeting.

AMA Board of Trustees Supplementary Report on Medical Society Membership Eligibility

Secretary Mauldin read a letter from the AMA on the above subject. The information was received as information.

Florida Citrus Commission Health Education and Nutrition Promotion

Mr. Krueger read the letter from the Florida Citrus Commission regarding their plans for a statewide program to emphasize the importance of health education and the awarding of a scholarship for advanced education to an outstanding teacher of health education in public schools in Georgia. The Commission invited MAG to appoint a representative to serve on an Advisory Committee to help shape the program and policy. On motion (McDaniel-Alexander) it was voted to ask the President to appoint a member to the Advisory Committee and to so notify the writer of the letter. Walter Bloom, Atlanta, was designated.

Progress of MAA Program

Medical Director Mauldin read a proposed Schedule of Estimated Monthly Reimbursable Costs to MAG with regard to the operation of the MAA program. On motion (Alexander-McDaniel) it was voted to approve the schedule of estimated monthly reimbursable costs and accept the amount determined as rental for the facilities used by MAA personnel. He also gave information on the progress of the program since January 1, and stated there was a large number of rejections due to diagnoses being improperly stated. Dr. Simon-ton recommended that an advisory committee be appointed to assist the Medical Director with the claims. Dr. Mauldin stated that such would have to be an Appeal Board, who would make recommendations to the Executive Committee. On motion duly made and seconded it was voted that Dr. Mauldin be directed to draw up a plan for an Appeal Board for submission to Executive Committee.

AMA Medical-Legal Meeting, May 18-19, 1962

Mr. Krueger stated that the MAG attorney would like to attend the meeting scheduled by the AMA for attorneys and executive secretaries representing state and county medical societies, May 18-19, 1962, at the Drake Hotel in Chicago. On motion (Goodwin-Atwater) it was voted to encourage the MAG attorney to attend but that no funds could be allotted for same.

National Foundation Scholarship Committee Nominations

Dr. McDaniel read a letter from the National Foundation regarding scholarships for medical students. On motion duly made and seconded it was voted to refer this matter to the Board of Medical Education with copies of the correspondence.

Medical Discipline Questionnaire

Dr. Mauldin discussed a questionnaire from the South Dakota State Medical Association regarding a medical discipline study. On motion (Goodwin-Mauldin) it was voted to refer this to the MAG Council at the March meeting, and to send copies of the questionnaire to members of Council at the time of the mailing of the agenda for the March meeting.

Employees Blue Cross Premium Increase

Mr. Krueger stated that due to increased hospital costs, the Atlanta Blue Cross group has increased the premium for MAG

employees about \$100.00 per year. On motion (Mauldin-Alexander) it was voted to take the money necessary to cover the increased premium from the Contingent Fund and pay the premium this year.

AMA Regional Aging Conference, April, 1962

Dr. Atwater, as Chairman of the Sub-Committee on Health Care of the Aging, gave the Executive Committee information regarding a conference to be held in Charlotte, North Carolina, April 13-14, 1962, and stated that he felt it most important that MAG have representatives in attendance. He will attend at AMA expense but he suggested that Doctors Simonton, Mauldin, J. Frank Walker and Mr. Krueger also attend. On motion (Bishop-Alexander) it was voted that funds be taken from the Health Care of the Aging Sub-Committee budget to send one individual, Dr. Mauldin having been selected, and if Dr. Mauldin cannot attend that Dr. Atwater should designate someone else.

Meriwether-Harris Problem Finale

Secretary Mauldin read a letter from Mr. Shackelford, MAG attorney, stating that the Meriwether-Harris County problem had been solved. A statement from the attorney for services rendered in connection with this problem was discussed. On

motion duly made and seconded it was voted that this fee for services be paid out of the Contingent Fund, as previously budgeted.

Annual Session Public Health Officers Section

Chairman Simonton stated that the Public Health Officers would like a section meeting on the scientific program at the MAG Annual Sessions. On motion (Alexander-McDaniel) it was voted to refer this to the Annual Session Board with instructions to investigate this matter and report back to Council.

Headquarters Office Report

Mr. Krueger reported on headquarters activities. He stated there was a need for another electric typewriter. On motion duly made and seconded it was voted to delay the purchase of any office equipment until the final budget figures are available. Mr. Krueger then explained the St. Paul Insurance Company's request for a premium increase in malpractice insurance. On motion (Mauldin-Simonton) it was voted to receive this report as information.

New Business

(a) Date and Site of March Executive Committee meeting: March 18, 1962, MAG Headquarters, Atlanta, immediately after Council meeting.

(b) Mr. Moffett gave a legislative report which was received for information.

(c) Chairman Simonton welcomed Rev. Paul McCleave and Mr. Richard Nelson from AMA Headquarters in Chicago.

There being no further business the meeting was adjourned at 4:20 P.M.

FELLOWSHIPS TO PROVIDE CLINICAL MEDICAL EXPERIENCE

Fellowships to provide a group of young Americans clinical medical experience in underdeveloped countries have been given to 33 junior and senior medical students, the Association of American Medical Colleges announced today.

The scholarships are made possible by a \$60,000 yearly grant from Smith Kline & French Laboratories, Philadelphia pharmaceutical firm. With the current selection, the Association in three years has awarded a total of 92 fellowships for study in 33 countries.

This year's winning students will travel to Thailand, Pakistan, the Philippines, Liberia, India, Tanganyika, Nigeria, Burma, Ethiopia, Peru, Uganda, Borneo, Madagascar, Haiti, Cameroun, Ecuador, Viet Nam, and Southern Rhodesia. They will work in mission hospitals and outpost medical facilities while studying

and combating diseases not commonly seen in the United States.

Although the fellowships are primarily to provide valuable clinical experience to American medical students, the students themselves help to bring modern American medical procedures to the areas in which they serve. At the same time, they gain "grass roots" experience with other cultures and their problems.

The students, chosen by a committee of prominent medical educators, spend at least ten to 12 weeks at their overseas locations. The amount of each award varies, depending on particular requirements.

The 1962 winners include one woman and 32 men. Five of the men will be accompanied by their wives who can qualify because of their training as medical students, nurses, or medical technicians.

AUGUSTA POSTGRADUATE ASSEMBLY

The Richmond County Medical Society sponsored the Augusta Postgraduate Medical Assembly at the auditorium of the Talmadge Memorial Hospital in Augusta on April 2-4, 1962. This time of year was very important to many doctors who play golf since it coincided with the practice rounds of the Masters Golf Tournament.

There were several guest speakers, including Robert Coffey, M.D., professor of Surgery, Georgetown Uni-

versity School of Medicine, Washington, D. C.; Carey M. Dougherty, M.D., Department of Obstetrics-Gynecology, LSU Medical School, New Orleans, Louisiana; Max Michael, M.D., Executive Director, Jacksonville Hospital's Educational Program, Inc., Jacksonville, Florida; Waldo Nelson, M.D., Professor of Pediatrics, Temple University Medical School, Philadelphia, Pennsylvania; and William F. Sheeley, M.D., Chief, General Practitioner Education Project, American Psychiatric Association. Local speakers rounded the program.

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Dr. John R. Seale of Richmond, England addresses Downtown Civitan Club, Atlanta on April 24, 1962.
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Our Association Future for 1962 - 1963

Thomas W. Goodwin, M.D., *Augusta*

President of the Medical Association of Georgia

PRESIDENT SIMONTON: First, let me thank you on behalf of my fellow members of the Medical Association of Georgia for your dedicated and efficient work on our behalf. During this past year in which you have served us as our president, your devotion to your task, your farsightedness, your personal sacrifice, and your dynamic leadership have been no small factor in enabling our organization to have a most outstanding year. You are a worthy predecessor; one in whose footsteps I am going to find it difficult to tread; one whose example is going to be difficult for me to follow. Let me assure you as I take up this office that I am going to do my dead level best not to let you and the Medical Association of Georgia down. I ask you for your continued help, guidance, and encouragement. Indeed, I ask these from all our members, our committees, our officers, and our Council.

Fellow members of the Medical Association of Georgia, I need not remind you that we are still engaged in the struggle against the increasing inroads of socialism in our country. These inroads are now even gnawing at the roots of private enterprise in our profession. We have already lost the first round. We lost it, in fact, years ago. We lost it when we began to fail to create at all times a good image of ourselves. When we allowed our public relations to degenerate and our relations with the press to become strained. When we allowed public opinion to picture us somewhat differently from what we really are and when we failed, in the main, to correct certain abuses which had arisen within our profession. We lost it when we failed to realize that we, like any other group of human beings, had certain people within our ranks who by virtue of their off color behavior brought discredit upon us all. In order not to lose another round, we must now dedicate ourselves. We must

gird ourselves for a long uphill fight; one which is going to be hard and one in which, likely or not, we are going to get bloodied before we are through. We must, therefore, set for the Medical Association of Georgia certain definite objectives, not only for the next year, but for the years to come.



THOMAS W. GOODWIN, M.D.
President 1962-63

Among our objectives certainly ought to be the continued support and strengthening of the medical education facilities in this state. We all recognize the need for more doctors in Georgia, particularly in the rural areas. We also recognize that as the field of medical care becomes more complex that we need provision for increased teaching and training.

It would be a good thing if the Medical Association of Georgia, working in conjunction with our two medical schools in this state, would sponsor postgraduate courses and programs on a regional basis in county hospitals over the state from time to time. This would be like bringing the "mountain to Mohammed" in order that doctors could more easily avail themselves of outstanding scientific programs and short courses. I would also point out to you the desperate need of another dental school in this state and would like to see the Medical Association of Georgia working actively toward that end. We should also work toward establishing closer relationships between hospital governing authorities and the medical staffs of those hospitals. There have been several problems which have arisen during the last few years as a result of the lack of cooperation between hospital authorities and medical staff groups in Georgia. We should also cooperate in every way with the Georgia Hospital-Medical Council in pushing our accreditation program for smaller hospitals on a voluntary basis. We definitely need closer liaison with the State Board of Health. During this past year, this lack of liaison has been pointed up on several occasions; notably, in the efforts of the State Board of Health to recodify its laws and in the negotiations of the State Board of Health with the hospitals in the State in regard to the State Aid Cancer Program. These negotiations, which were conducted without consulting the Medical Association of Georgia, would have resulted in the closing down of the State Cancer Program entirely had it not been for the timely intervention by the Governor in making additional funds available.

Medical Disciplinary Board

There will be brought before the House of Delegates at this session, the consideration of the advisability of asking the Georgia General Assembly to set up a medical disciplinary board. This board should have the authority and the function of any other state board. It would be backed in its actions by law. It would have subpoena powers and its members would be immune to suit. The members of this board would be elected, one from each district, by the doctors in that district. This board would have the power to revoke one's license to practice medicine.

We also need, more and more in the years to come, to increase our legislative and political activities. We are all familiar with the so-called health programs of the present federal administration. It is unnecessary to explain to this audience why the adoption of this program will mean the lowering of good medical

practice in this country. The history of similar programs elsewhere is sufficient proof of that. I cannot share the optimism of some of the leaders in organized medicine that the peak of this danger has been passed. This is a battle that medicine can never win in any one year or for some years to come; but it can lose at any moment. The enemy may run away now, but he will live to fight another day. I believe firmly that alone medicine cannot continue to fight successfully upon the political battlefield. I am convinced that our only hope of ultimate victory lies in our realization that profound social changes have already occurred which neither we nor anyone else can reverse. We must make an honest effort to adjust free medical practice to these changes. I hasten to add that by "adjustment" I do not mean any concession of principle—nor do I think that any concession of principle need ever be considered. We must remember, however, that we have passed, and may still be passing, through a slow revolution in which the pendulum never returns to center. We have no choice but to measure our actions by the position of the pendulum at any given time. The pendulum at this time has swung rather sharply to the "left." This is the doings of a group of shrewd and dedicated politicians whose ideas vary considerably from ours as to what is good, not only for the medical profession, but for the entire economy of our country at large. We are at heart a conservative group of people and, as conservatives, we deplore some of the things which we see. We deplore the ever increasing trend toward centralization of government. We deplore the persistent efforts to strengthen the power of the federal government at the expense of the states in defiance of the Constitution. We deplore the policy of fiscal irresponsibility, of useless give-away programs, and the condoning of the numerous socialistic trends in this country. We deplore the "no win" policy of our State Department and we deplore the fact that there seems to be a breakdown in the moral fibre of our people. This has gone on to the point where we are now turning our backs on the very principles which made America great. These principles of individual initiative, honor, and enterprise seem to have been lost in an effort on the part of our people to find security which far too many think can only be provided by an all powerful benevolent federal government. We also deplore the present efforts which are being made to socialize the practice of medicine and we make no apology for it.

Since we are conservatives, it is up to us to make our influence felt. This we can best do by working through political action committees. We can and should say to our representatives in Congress that we expect them to listen to us and that we expect

conservative, sensible political behavior on their part or else they can no longer count on our support. We, in the medical profession, have an opportunity, if we will, to make ourselves the rallying point of all the conservative forces in this country regardless of their political party. We must make all our friends see that for now we are the ones that are under the gun, but that later it will be some other segment of our economy that is under attack. The thing that the powers that be in Washington are really interested in is changing a political philosophy. What is happening to the medical profession is simply a symptom of the over-all disease which is affecting our country as a whole. This disease, in a nut shell, is due to the creeping virus of socialism which has affected our country since the close of World War I. We must enlist the aid of all of our conservative friends in business, manufacture, commerce, farming, law, and religion if we are going to see things through.

We must make our friends realize that when doctors fight to protect themselves, they are fighting

to protect them and their right to invest in a business of their own and run it as a free enterprise. In my opinion the very welfare and future of our country is at stake. This is a holding action and what happens to us as doctors is really important because it does very vitally affect the welfare of all our people. We must broaden our scope of influence in every way possible by forceful argument, by fearless standing for our principles regardless of what the cost may be. We must work and fight and pray. We should, by every means at our command, do everything that we can to see to it that a conservative Congress is elected this year and a conservative administration is elected two years hence. This is the only way that we can stem this ever rising tide of socialism in this country. It will be then and then only that the day of the return to the principles upon which this country was founded will be effected. It will be then that the day of salvation will be at hand. And, after the day of salvation, as sure as day follows night, will come the years of redemption.

1467 Harper Street

SOME FACTS CONCERNING NATION-WIDE STATUS OF THE CIVIL DEFENSE EMERGENCY HOSPITAL

There are presently 1,930 Federally-acquired civil defense emergency hospitals of which 1,907 are prepositioned in the 50 States, the District of Columbia, Puerto Rico and the Virgin Islands. Of the remaining 23, 15 are in depots for rehabilitation and eight are unassigned.

Because of problems with communication, transportation, and other factors, stockpile depots cannot be relied upon to augment civil defense emergency hospitals and community emergency medical care operations immediately post-attack. Since the transfer of responsibility for the medical stockpile to the Department of Health, Education and Welfare, policy has been established to disperse the depot medical stocks as rapidly and completely as possible so that supplies are immediately available post-attack at the *State and community level*.

The immediate plan entails the dispersal of medical supplies sufficient to increase the civil defense emergency hospital operational capability from three to four days to 30 days. All supply items (excluding equipment) common to those in existing civil defense emergency hospitals are involved in the expansion from a three to four day supply to the projected 30-day supply. The supplies required for expansion will come from bulk stocks in warehouses or through new procurement. The additional space requirement for the expansion unit is 1,665 cu. ft. which doubles the storage space requirement for the total hospital unit.

The deficiencies which develop in propositioned civil defense emergency hospitals usually fall into the categories of inadequate storage facilities and methods,

heating, refrigeration, flammable storage, insect infestation, water damage and shelf life deterioration of components. The States and local communities cannot perform maintenance of a technical nature such as is needed on instruments of precision and in the exchange of fresh stocks for deteriorated materials. The States can and should correct deficiencies in the categories of storage facilities and storage conditions. Inventory accountability remains in the Federal Government.

The hospital component purchases are designed to attain maximum shelf life. Specifications are developed for purchase of the most stable forms of drugs and the best protective packing and packaging for all items. Many of the CDEH components can remain in long-term storage without deterioration problems. Some of the items are definitely perishable and with time deteriorate to the extent that they must be replaced. Adverse storage conditions (heat, humidity, lack of refrigeration) at many prepositioned sites hastens this deterioration. Packaging failure is often a factor in deterioration. A comprehensive stock surveillance and quality control program has been established to systematically inspect, sample and test the medical stockpile items. Deteriorated items are thereby identified and disposed of. Some of the stockpile materials, including perishables, are ten years and older. The deterioration problem has therefore accumulated and is growing. The quality control program will be accelerated. Funds will be required for replacement stocks.

(Excerpted from a statement by James M. Hundley, M.D., Assistant Surgeon General, U.S.P.H.S.)

USE OF RENAL FUNCTION TESTS IN SURGICAL PRACTICE

Jack Lapides, M.D., *Ann Arbor, Michigan*

- ***In the author's experience, the 15 minute P.S.P. determination and the serum creatinine level are most useful in pre-operative evaluation of kidney reserve.***

WHEN A SURGEON FIRST considers a patient as a candidate for an operative procedure, many questions arise in his mind; and some of these are 1) Is the operation indicated? 2) Must the procedure be done within the immediate future or can it be delayed for some time? 3) If immediate surgery is warranted, should it be extensive, prolonged, hemorrhagic procedure A or would it be better to do short, simple procedure B and use postoperative irradiation? 4) If the operation is elective, can it be performed now or would it be preferable to delay for awhile?

The answers to these questions not only depend upon the disease entity justifying surgery but also upon the status of the patient's primary homeostatic organs such as the heart, lungs, liver and kidneys. If the important homeostatic mechanisms are in good shape, the physician can select the radical procedure in the patient with the neoplasm or schedule the elective operation immediately. A major deficit in function of the heart, lungs or kidneys might force postponement of the elective procedure or selection of a less radical operation.

In this paper I would like to confine my remarks to the renal homeostatic mechanism. It has been shown by many investigators^{1, 2, 3} that major operations as well as general anesthesia produce varying degrees of temporary impairment of both tubular and glomerular function, as manifested by a decrease in renal blood flow, glomerular filtration rate, sodium excretion, urine osmolality and urine volume. It is obvious that a diseased kidney will be

less able to withstand the rigors of operation than a healthy kidney and that a preoperative impaired kidney might make the patient's postoperative course quite precarious. Thus the preoperative estimation of renal function becomes quite important. Another excellent reason for obtaining accurate evaluation of the kidneys is the occasional occurrence of oliguria or anuria following surgery. Valuable aid in the diagnosis and treatment of renal failure can be obtained from an accurate preoperative appraisal of the patient's renal function. Now, how does one evaluate renal function on a practical, clinical basis?

Modern Concepts

Before discussing methods for estimating renal dynamics, it would be most appropriate to present a bird's-eye view of the modern concept of kidney function. Each kidney is composed of one million nephrons which are the units involved in performing the homeostatic duties of the organ. The nephron is composed of the glomerulus, proximal convoluted tubule, loop of Henle, distal convoluted tubule and a portion of the collecting tubule. It is important to remember that the normal function of the nephron depends upon its blood supply. The capillaries of the glomerulus arise from the afferent arteriole and then join to form the efferent arteriole. It is to be noted that the only blood supply to the tubular portion of the nephron comes from the efferent arteriole of the glomerulus through the peritubular capillary network. As a result of this arrangement it is apparent that any interference with the blood flow through the glomerulus will compromise the blood supply and function of the tubular

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cells. This point will be enlarged upon when renal function tests are discussed.

The nephron utilizes three major mechanisms in its efforts to maintain a normal constant environment for the cell of the body and these are glomerular filtration, tubular reabsorption and tubular excretion. The blood plasma conveys the environment of the cells or extracellular fluids to the glomerulus. In the blood plasma are end products of metabolic processes and ingested foodstuffs and fluids. Some of the substances in the plasma are needed by the organism while others are unnecessary, undesirable and destined for excretion from the body. The first step in "purifying" the extracellular fluid is the filtration of the plasma by the glomeruli. The glomerular filtrate is essentially the same as the plasma except for the absence of most of the protein, erythrocytes, leukocytes and substances of large molecular structure. As the glomerular filtrate passes through the tubule certain desired substances are reabsorbed by the tubular cells and placed back into circulation, while others are permitted to flow down into the urinary excretory conduits. A few of the substances which are filtered by the glomerulus are also excreted by the tubular cells. The byproduct of all the tubular homeostatic activity is urine. It is the solution remaining after the kidney has removed all of the solute and solvent necessary for providing an optimal environment for cellular activities.

Uremia

The disturbance resulting most frequently from renal dysfunction has been called uremia and is due primarily to impairment of glomerular filtration. It is characterized by an abnormal increase in the serum or blood level of non-protein nitrogen, urea nitrogen, creatinine, sulfates and phosphates. These substances are being formed constantly by the metabolic breakdown of proteins and are eliminated from the body primarily through the kidneys. The end products of carbohydrate and fat metabolism are carbon dioxide and water which can be excreted through the lungs and skin. Thus when renal function is impaired, it is primarily the end products of protein metabolism which accumulate in the extracellular fluid. The phosphates and sulfates tend to produce acidosis and result in the decreased serum bicarbonate in the body's attempt to neutralize the acids with sodium bicarbonate.

It has been demonstrated that the glomerular filtration rate must be reduced to approximately 25 per cent of normal before the end products of protein metabolism begin to accumulate appreciably in the extracellular fluid. In essence, this means that the BUN and NPN determinations remain ap-

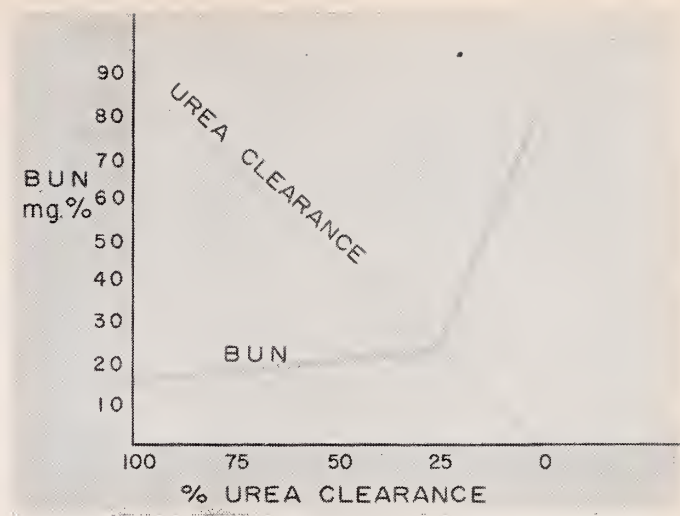


Figure 1

proximately normal until 75 per cent of total renal function has been impaired; and it is only then that one observes a marked rise in the BUN and NPN values. (Figure 1).

Thus serious errors in the preoperative estimation of renal function can occur if one relies upon the BUN and NPN as indicators, for with these determinations the surgeon cannot distinguish between the kidney that is 100 per cent of normal and one which has lost the use of more than 1/2 its glomeruli and is on the verge of causing uremia. There are other disadvantages to the use of the BUN determination as an accurate indicator of renal function. Not infrequently elevated BUN levels are observed in situations where renal function is perfectly normal e.g. in breakdown of erythrocytes in the gastrointestinal tract and other body spaces following hemorrhage into these areas; in the massive necrosis of body tissues such as in rampant infections or gangrenous extremities; or in marked dehydration. Conversely the BUN and NPN level may be normal in situations where renal function is markedly impaired. Since urea nitrogen is formed in the liver, it is apparent that a patient with severe liver disease may demonstrate low BUN levels in the face of poor renal function. What then is the role of the BUN determination? It is a useful guide in following the daily progress of a patient's kidneys after an initial accurate estimation of renal function has been made by means of other tests.

PSP Test

From the practical viewpoint I believe that the 15 minute PSP test⁴ is the most efficient initial method of screening the status of a patient's kidneys. It is most efficient because it can be performed rapidly by the physician himself in his office or on the ward with nothing more than a set of PSP standards. The PSP test is primarily a measure of tubular function since most of it gets into the urine

RENAL FUNCTION TESTS / Lapidus

by tubular excretion and only a small portion by glomerular filtration. However, if the PSP dye excretion in 15 minutes is 30-35 per cent of the injected amount, then it implies that both tubular and glomerular function are 100 per cent of normal for one cannot have perfectly functioning tubules without an adequate blood flow from normal glomeruli.

If the PSP excretion in 15 minutes is less than normal, it may mean that tubular function is impaired or that there is delayed conduction of urine from the calyces down to the specimen bottle as in hydronephrosis, hydroureter and partial urinary retention. When the 15 minutes PSP excretion is below normal, glomerular function becomes an unknown and must be determined by a more direct method for measuring glomerular filtration. The reason for this statement lies in the fact that the condition of the tubules does not necessarily influence glomerular function. The disease that impaired tubular function may have confined itself to the tubules as for example in pyelonephritis or interstitial nephritis, without affecting the glomeruli. This is in contrast to glomerular disease which, although attacking the glomerulus itself, affects tubular function indirectly by compromising its blood supply.

Glomerular Function

Thus it behooves the physician to perform further tests to determine the status of the glomeruli for it is glomerular function which ultimately influences the surgeon's decision. Clinically glomerular filtration rate is determined by either the urea clearance or the 24 hour endogenous creatinine clearance methods. The urea clearance test requires the collection of two one-hour specimens of urine and a blood sample drawn at the start of the collection of the second hourly urine specimen. Normal kidneys will exhibit a urea clearance of 75 to 125 per cent. The creatinine clearance method necessitates the collection of urine for a period of 24 hours and the procurement of a blood specimen at the end of the urine collection period. Normal creatinine clearance is approximately 140 ± 20 liters in 24 hours. The creatinine clearance test tends to be more accurate than the urea clearance method for several reasons. First a given time error in collection of the urine specimen will affect the urea clearance more than the creatinine clearance methods e.g. 10 minute error in a one hour collection is of much greater significance than a 10 minute error in a 24 hour urine specimen. Secondly, extrarenal factors influence urine and blood urea nitrogen levels to a greater degree than creatinine levels. Finally, most

non-automated laboratories seem to be able to determine the creatinine in body fluids with greater facility and fewer errors than the urea nitrogen.

Although it would appear that the urea and creatinine clearance methods are simple to perform, a study of the records of many hospital laboratories would reveal that 25 per cent or more of requested tests were invalid because of inaccurate urine collections. For this reason many physicians refuse to waste valuable time in attempting to obtain an accurate clearance test and instead fall back upon the BUN determination.

Urine Collection

We, too, have had difficulties in obtaining accurate urine collections not only because of errors made by orderlies and nurse aides, but also because of mistakes committed by patients with inherited and acquired cerebral dullness. In an effort to avoid utilizing tests requiring prolonged periods of urine collection we made a study of the relationship between serum creatinine and creatinine clearance in a number of patients with normal and impaired renal function. Particular effort was exerted in the case of these patients to obtain accurate urine collections. No special conditions such as a particular diet or fluid restrictions were used in performing the creatinine clearance tests. Over 300 cases of adult male and female patients were analyzed. When all of the patients with marked muscle atrophy were deleted from the series, one could observe, within limits, a straight-line relationship between the serum creatinine level and the 24 hour endogenous creatinine clearance (Figure 2). If we

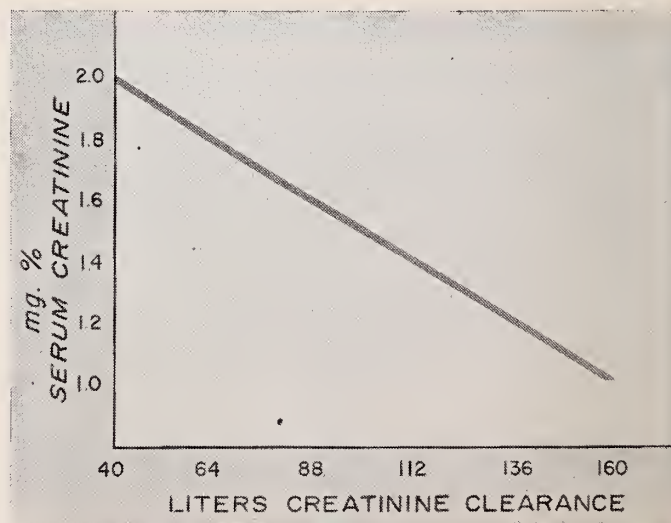


Figure 2

consider 160 liters creatinine clearance to be evidence of 100 per cent normal glomerular filtration and 40 liters to be 25 per cent of normal, then one can plot the serum creatinine level against per cent of normal glomerular filtration rate and obtain the

curve illustrated in Figure 3. Thus a serum creatinine of 1.0 mg. per cent indicates perfectly normal glomerular function; a serum creatinine of 1.5 connotes 63 per cent of normal glomerular function; and a serum creatinine of 2.0 mg. per cent indicates a kidney on the verge of not being able to maintain homeostasis or 25 per cent of normal glomerular function.

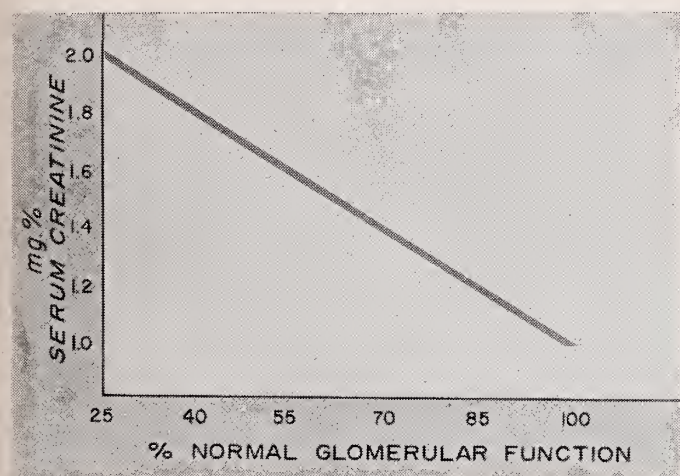


Figure 3

Now how do we actually use the 15 minute PSP test and the serum creatinine level in evaluating a patient's renal function? When the results of the PSP test are compatible with the serum creatinine, then one can assume in most instances that an accurate appraisal of renal function has been obtained. For example, a 15 min. PSP excretion of 25-35 per cent is compatible with a serum creatinine of 0.8-1.2 mg. per cent and indicates essentially normal kidneys. Similarly a PSP of five-ten per cent and a serum creatinine of 1.9-2.1 mg. per cent jibe and are compatible with poor renal function. Now let us suppose that in a particular patient the PSP test indicates an excretion of 30 per cent of the dye or tubular function of 100 per cent while the serum creatinine level is 1.8 mg. per cent or an equivalent glomerular function of approximately 40 per cent. These values are incompatible for, except in rare instances, the tubular function cannot be better than glomerular function; therefore, something is wrong and both tests should be redetermined.

Let us examine another situation wherein the 15 minute PSP value is five per cent dye excretion and

the serum creatinine is 1.3 mg. per cent. When the values are converted to per cent of renal function, one obtains a tubular function of approximately 15 per cent of normal and a glomerular function of 75 per cent of normal. These results are compatible for, as mentioned previously, tubular function can be affected by disease localized to the tubules such as pyelonephritis without compromising glomerular function; or the divergence may be the result of urinary retention either in the kidney pelvis and ureters or in the bladder—a situation which prevents accurate collection of the volume of urine excreted by the kidneys in the 15 minutes following intravenous injection of the phenolsulfonphthalein. Accordingly it is obligatory for the physician to investigate the patient's urinary conduits for evidence of obstructive uropathy.

In general it has been observed that patients with a serum creatinine of less than 1.5 mg. per cent or with a 15 min. PSP excretion of more than 15 per cent, will tolerate most major operative procedures quite well. On the other hand individuals with a serum creatinine of more than 1.8 mg. per cent will bear considerable deliberation before being subjected to a prolonged hemorrhagic procedure under general anesthesia.

In summary, it can be stated that all patients being considered for surgery, should have their renal function evaluated accurately before operation. From a clinical viewpoint this can be accomplished most efficiently with the determination of the 15 minute PSP test and the serum creatinine level in each patient. The BUN and NPN values are poor excuses for base line renal function tests and should be used only for serial follow-up evaluation of renal function after base line studies of PSP and serum creatinine have been obtained.

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SCIENTISTS IN INDUSTRY

Three decades ago most scientists looked down their noses at offers of research jobs in industry. Now, working in well-paid posts . . . some of the country's ablest bacteriologists, chemists, and pharmacologists have made possible the most imposing series of scientific developments ever compressed in such a short span of

time. Thousands of people are alive and well today who ten years ago could have died without antibiotics, steroid hormones, and anticoagulants. Many of the one-time killers have been robbed of their terror by heavily-backed industrial research.—Marguerite Clark, medicine editor of *Newsweek*, in *Medicine Today*.

CALCIFICATION OF INTERVERTEBRAL DISKS IN CHILDREN

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■ *The report of a case and a review of the literature.*

Introduction

CALCIFICATION OF THE INTERVERTEBRAL disk is not an uncommon finding in adults, particularly in the elderly, but disk calcification in children is unusual.

In adults, disk calcification is almost always permanent and unchanging, in which case it is considered of no clinical significance. In adults it occurs most frequently in the mid-dorsal and lumbar regions and is considered a degenerative change associated with normal aging.

In contrast, there is some question concerning the significance of disk calcification in infancy and childhood. In the 39 cases reported the cervical spine has been most commonly involved and in nearly all of the latter there has been eventual decalcification of the disk.

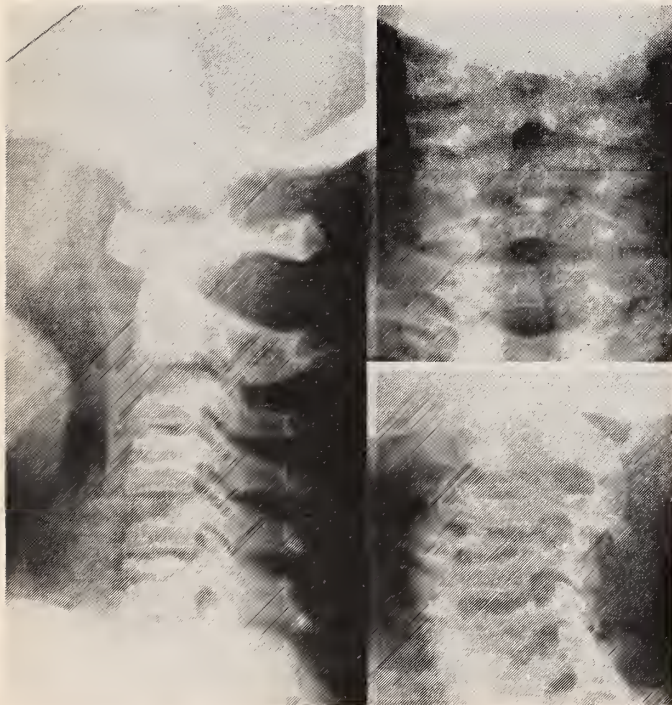


Figure 1A



Figure 1B

In adults, the calcification, which may involve any part of the disk, is predominantly annular, whereas in childhood, the calcification in almost all reported cases has been nuclear.

The following case report serves as a focal point for analysis of the clinical significance of such calcifications in the previously reported patients.

Case Report

B. H., an 8 11/12 year old white male was seen on 3-11-60 complaining of severe recurrent occipital headache and upper posterior neckache of two

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week's duration. The patient stated that it began about three-five hours after he had batted a hard-pitched ball during a baseball game. For the first week and a half following this, the discomfort was intermittent and occurred primarily during the day-time and evening. He had almost constant severe discomfort the entire 48 hours prior to being seen. There was no nausea or vomiting. The pain did not seem to be relieved by any medication and only slightly by rest. He had been doing very poorly at school scholastically and in behavior.

Physical examination was not remarkable except for vision testing which revealed 20/50 vision in each eye using a standard Snellen chart. The blood pressure was 104/60. Skull x-rays were negative. X-rays of the cervical spine revealed dense calcification of the nucleus pulposus at C3-C4 and C5-C6 (Figures 1A and 1B). On a roentgenogram of the chest taken 2½ years previously (7-25-57), these calcifications of the cervical disks were noted in retrospect (Figure 2).

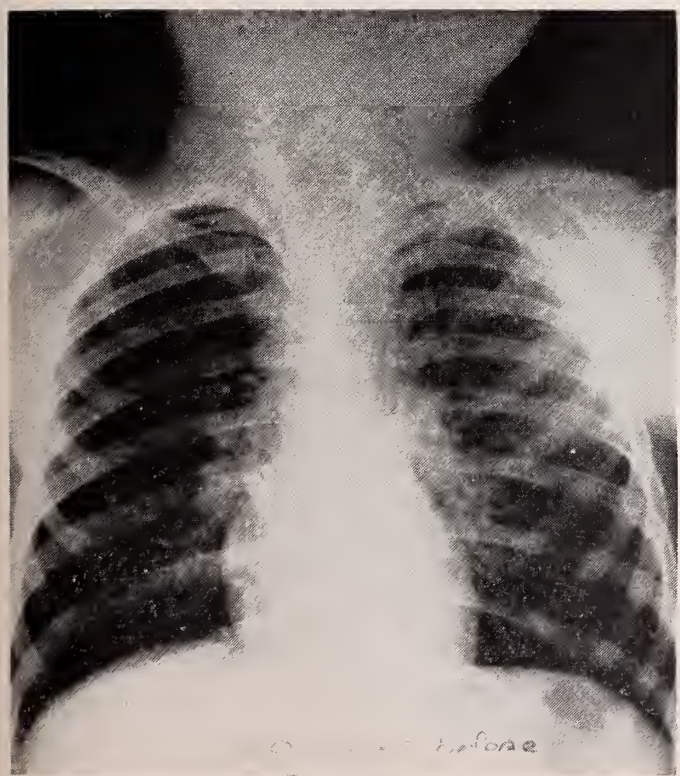


Figure 2

The consulting ophthalmologist found his vision to be 20/70 in both eyes with perfectly clear mediae. Fundi were normal. Glasses were prescribed, which improved his vision to 20/20 in each eye. After only several days of wearing glasses, the patient's severe symptoms completely subsided. There was subsequent remarkable improvement in his scholastic work and deportment at school. This improvement has been maintained. Repeat roentgenograms of the

cervical spine on 6-10-60 and 4-4-61 revealed no change in the disk calcifications.

History

Although Luschka²¹ in 1858 described in anatomic specimens of intervertebral disks areas which probably represented increased calcium content, Calvé and Galland⁴ in 1922 were the first to show radiographically intervertebral disk calcification in a living adult. Baron² in 1924 first reported a case of calcification of thoracic and lumbar disks in a child and Lyon¹⁴ in 1932 published the first case of cervical disk calcification in childhood. Since then a total of 25 cervical and 14 non-cervical cases has been reported. This includes all found in the English language literature and some in the foreign literature.

The films in most instances were taken because of persistent localized pain, and muscle spasm, with associated deformity. Some patients also presented evidence of infection, or a history of recent trauma, or both. The disk calcification was infrequently an incidental finding.

Weens²⁶ and Silverman²³ have previously published extensive reviews.

Disk Anatomy

The intervertebral disk is a unit which acts as a hydraulic ball bearing and shock-absorbing mechanism. It consists of three parts: the *nucleus pulposus*,

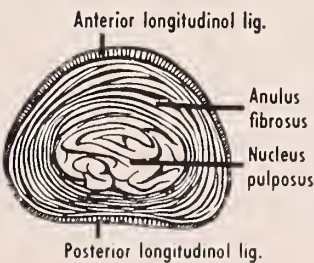
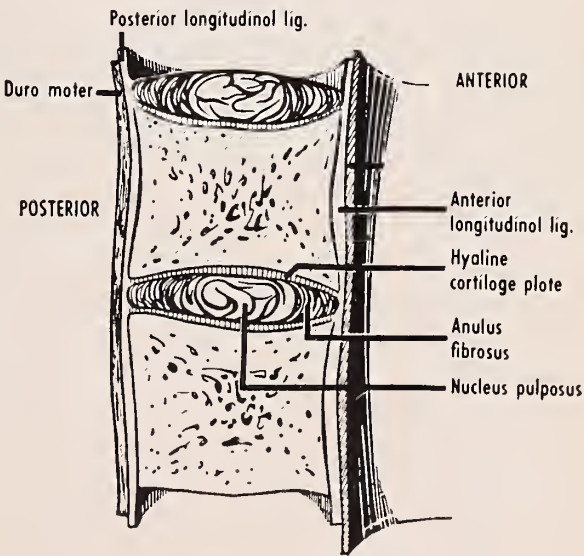


Figure 3

INTERVERTEBRAL DISKS / Continued

the *annulus fibrosus*, and the thin hyaline *cartilage plates* bordering the adjacent vertebral bodies (Figure 3).

The nucleus is encapsulated by the annulus fibrosus, which is anchored to the cartilage plate and ring epiphysis above and below and fuses with the longitudinal ligaments anteriorly and posteriorly. The nucleus pulposus is semi-gelatinous, consisting of collagenous fibers, a few connective tissue and cartilage cells and much amorphous intercellular substance. The fluid-like nucleus is highly plastic and non-compressible.

The annulus fibrosus is compressible but elastic, composed of concentric rings of collagenous fibers and fibrocartilage. With increasing age the fibrous content of the nucleus gradually increases, and the water content and elasticity decrease. During the third decade the nucleus begins to blend more intimately with the annulus and in later years the entire disk tends to become fibrocartilaginous and the structural differences between the annulus and the nucleus are often lost.

The nucleus pulposus and the annulus fibrosus have no blood supply. There are vascular channels in the cartilaginous plates which disappear within the first three decades of life. In the study of Coventry et al,⁶ none of the anatomic specimens beyond the age of 19 years showed vascular channels.

Disk Calcification

In adults calcification usually involves the annulus and the plates with occasional involvement of the nucleus or of the whole disk. In childhood the calcification is usually confined to the nucleus and to the adjacent part of the annulus.

Why disks calcify in children is not known, but the mechanism appears unrelated to the calcification that occurs in older people as part of a degenerative process, and unrelated to conditions characterized by hypercalcemia. Alkaptonuric ochronosis with disk calcification has not been encountered in childhood.

Mild trauma is so common in childhood that one would expect disk calcification to be much more common if this were the significant factor. Although there are no blood vessels in the nucleus, Schorr and Adler²² suggested that trauma might be associated with hemorrhage into the nucleus with subsequent calcification. It is known that hemorrhage in the soft tissues of an extremity of a child may begin calcifying radiographically within one to two weeks. Calcification *around* a disk has been described by Lindbom¹³ in 11 days following injury to the cervical spine of a 20-year-old male. This was

associated with disk narrowing but no fracture.

A metastatic infectious process has been suggested by some authors whose patients had fever, elevated sedimentation rate and leucocytosis at the time the disk calcification was discovered.

The reversibility of nuclear calcification in childhood in contrast to the usual permanence of calcification of the disk in adults is probably related to the integrity of the vascular channels in the cartilage plates which disappear in adulthood.

Discussion

This case represents the 39th reported child with calcification of an intervertebral disk. It is felt that symptoms in this boy were due to a refractive error and had no relationship to the calcification, since the latter was present 2½ years prior to symptoms and was unchanged one year later. Analysis of the other 38 cases also leads one to the conclusion that the production of disk calcification in most children is unrelated to the presenting symptoms, whether infectious, traumatic, or otherwise. This conclusion has been reached by others.¹⁸

No symptomatic cases were reported in which calcification was not present on the original x-ray examination and later appeared. Thus, there is no evidence as to how long it takes for a disk to calcify. It seems unlikely that radiographically demonstrable calcification could be produced in two weeks' time or less. Yet, in 23 cases out of 39, the first positive x-ray was made two weeks or less after symptom onset, or else preceded symptoms or was an obviously incidental finding. In fact, 27 per cent of the combined group had disk calcification demonstrated prior to the onset of symptoms or as an incidental finding.

Indeed, if there is any relationship between disk calcification and symptoms, it appears more likely that the clinical episode might initiate physico-chemical changes resulting in de-calcification of an already calcified disk, rather than producing calcification. Of fundamental importance is the question: how long does it take calcification to disappear once the resorption process has begun? The answer to this question is unknown. The analogy is often drawn to calcific peritendinitis. Calcifications discovered following the onset of symptoms of this entity often regress or disappear in three to 12 weeks. In only approximately ten per cent or less of the disk cases was the calcification gone or reduced within three months after onset of symptoms. It would appear, therefore, that in most cases the symptomatology may have had nothing to do with the process of decalcification which ultimately ensued.

It is interesting to note that in none of the re-

REPORTED CASES OF CALCIFICATION OF CERVICAL INTERVERTEBRAL DISKS IN CHILDREN

Author and Year	Age, Sex, and Race of Patient	1. Signs and Symptoms 2. Laboratory Findings	Time Relationship of Symptoms and Disk Calcification	Disks Involved	Time of Clinical Recovery	Duration of Calcification
Lyon ¹⁴ (1932)	8 yrs. Male	1. †Pain in neck; head inclined to right; sudden onset; irritability; fever. 2. Not reported.	1st film 3 wks. after onset.	C6-C7 (nuclear)	Completely well in 12 days.	8 mos.
von Held ⁸ (1934)	10 yrs.	1. †Sudden onset; cold; fever; pain left shoulder, neck and head with limitation of motion; tonsillitis; hyperextended neck; head inclined to left. 2. Not reported.	1st film 2 wks. after onset.	C2-C3 C3-C4 C5-C6 (nuclear)	Well in 2 mos.	Almost gone after 2½ mos.
Keyzer ⁹ (1939)	2½ yrs. Male	1. †Sudden onset; severe neck and head pain; fever; marked neck stiffness. 2. WBC of 14,000 with normal differential. Tuberculin and typhoid tests negative. Blood culture showed hem. streptococci.	1st film 1 mo. after onset.	C2-C3 C3-C4 C4-C5 (nuclear)	After febrile course of 5 wks. complete recovery.	No change after several months.
Weens ²⁶ (1945)	5 yrs. Female	1. †Marked pain back of head and neck; aching of neck few mos. prior; diagnosed myositis; fever of 100° (F) and 120 pulse; neck hypertension; small cervical nodes. 2. Eosinophilia (due to Ascariasis?)	Noted on chest film several mos. prior to symptoms.	C6-C7 (nuclear)	Well in 1-2 wks.	Gone 4 mos. after symptom onset.
Lasserre and Phelipott ¹¹ (1947)	11 yrs. Female	1. Pain, left scapula; torticollis; afebrile. 2. Not reported.	1st film 1 mo. after onset.	C6-C7 C7-T1 (nuclear)	Not known.	Not known.
Silverman ²³ (1954)	7¾ yrs. Male White	1. †Acute stiff neck; sore throat 2-3 days before onset; slight fever; few cervical nodes. 2. Not remarkable.	1st film made 2 wks. after onset.	C6-C7 (nuclear)	Well in 6 days.	Completely gone 15 mos. later.
	11 yrs. Male White	1. Acute torticollis; afebrile. 2. Urine negative for homogenetic acid.	1st film made day of onset.	C5-C6 (nuclear)	Well in 2-3 days.	Largely gone after 6 mos.
Schorr and Adler ²² (1954)	8 yrs. Male	1. *Fell in tub. Next day severe neck pain and torticollis. 2. None reported.	1st film 6 days after onset. Also had wedge-shaped compression fracture, 6th cer. vert. body.	C6-C7 (nuclear)	Free of symptoms after 2 weeks. Neck immobilized.	Almost gone 8 days later. Completely gone 1½ mos. after fall.
Peacher and Storrs ¹⁷ (1956)	5 yrs. Male	1. *Pain over and to right of post. cervical spine for 3 days following fall from sofa; burning in right pharynx; few URI's, dental caries and cervical lymphadenopathy few mos. prior. 2. Lab studies negative.	1st film made 3 days after onset. Chest x-ray shortly after birth revealed no calcification of cervical disks.	C4-C5 (nuclear)	Well after 7 days of traction.	Almost gone 2 yrs., 8 mos. later.
	4 yrs. Male	1. Severe neck pain and anorexia 7 days; afebrile; restricted neck motion; spasm of right sternocleidomastoid muscle. 2. Not remarkable.	1st film 7 days after onset.	C3-C4 (nuclear)	Well in 3 days.	Almost gone 4 mos. later.
Rechtman et al ¹⁹ (1956)	3 yrs. Female White	1. Left torticollis. 2. Not remarkable.	1st x-ray 2 days after onset.	C4-C5 (nuclear)	Well in 4 days.	Almost complete disappearance after 27 mos.
	5 yrs. Male	1. *2 wks. prior to current episode, tonsillitis, fever, cervical adenitis. Recovered. 5 days later, was tumbling, then stiff neck, right head pain, left torticollis. Flattening left skull from antecedent torticollis. 2. Usual tests normal.	1st film made 6 days after onset.	C4-C5 (nuclear)	Well about 2 wks. after onset of torticollis.	21 mos. later calcification had disappeared except for 2 pinhead-sized calcific flakes.

*Trauma

†Infection

REPORTED CASES OF CALCIFICATION OF CERVICAL INTERVERTEBRAL DISKS IN CHILDREN

Author and Year	Age, Sex, and Race of Patient	1. Signs and Symptoms 2. Laboratory Findings	Time Relationship of Symptoms and Disk Calcification	Disks Involved	Time of Clinical Recovery	Duration of Calcification
Mann ¹⁵ (1957)	9 yrs. Male Negro	1. Pain, stiffness in neck and right shoulder. Weakness of right shoulder and arm. 2. Throat and NP cultures grew Hem. staph. aureus, Neisseria species. H. hemolyticus.	1st film made 3 wks. after onset.	C4-C5 L4-L5 L5-S1 (nuclear)	Pain gone in 2 mos. and weakness in 8 mos.	After 7 mos. C4-C5 calcification gone; L5-S1, no change; and early calcification at L4-L5 noted for 1st time.
Newton ¹⁶ (1958)	7 yrs. Male White	1. *Stiff neck. 3 days prior to onset had fallen 5 feet landing on back of neck. 2. Lab test results normal.	1st film 3 days after onset.	C6-C7 (nuclear) also area anterior to C5-C6	After 15 days only slight limitation of motion.	1st follow-up film 11 yrs. later was negative.
	5 yrs. Male White	1. *Following fall down stairs, left shoulder and neck pain for 2 wks. 2. Wbc from 13,200-16,900 with normal differential.	Calcification preceded symptoms by 2 yrs.	C5-C6 (nuclear)	Well 16 days after admission.	Possibly 13 yrs. 1st noted at age 3 yrs. (asymptomatic). Diminished at age 5 yrs. Gone at age 16 yrs.
	6 yrs. Male White	1. *Neck pain since tree fall 1 yr. earlier. Tender over 5th and 6th cer. Vert. 2. Usual tests negative.	1st film made 1 yr. after onset.	C5-C6 (nuclear)	Well 2½ yrs. after onset.	5½ yrs. later only fleck noted.
	10 yrs. Male White	1. †Clinical diagnosis of transverse myelitis, etiology unknown, 4th cervical level. 2. Routine lab tests and CSF normal.	1st x-ray 6 days after onset.	C4-C5 (nuclear)	Only residuals 5 yrs. later, isolated weakness of right shoulder girdle and Thoracolumbar scoliosis.	5 yrs. later faint, hazy density still present.
	10 yrs. Female White	1. Painful neck, held tilted to right. 2. Usual tests negative.	1st film 3 wks. after onset.	C4-C5 (nuclear)	Full range of motion, but still intermittent neck pains 2 yrs. later.	4 yrs. later partial resolution.
	7 yrs. Male White	1. †Fever, sore throat, headache, stiff neck. Well after 3 days of penicillin. Then neck pain and fever recurred. 2. Wbc. of 17,000 with normal diff. Sed. rate of 33.	1st film 10 days after onset.	C6-C7 (nuclear)	Well 14 days after onset.	Disappeared after 5 mos.
	3 yrs. Male White	1. Stiff neck and pain on motion. 2. None reported.	1st film 4 days after onset.	C3-C4 (nuclear)	Well 9 days after onset.	Partial resolution 3 wks. later.
Pierce and Hanafée ¹⁸ (1960)	7 yrs. Male White	1. *(†?) Neck, right shoulder pain; slight fever; slight cervical lymphadenopathy; left sternocleidomastoid m. spasm. 2 recent falls. 2. Usual tests normal.	1st x-ray made 3 wks. after onset. (X-ray made at age 2½ yrs. showed no disk calcification.)	C4-C5 C6-C7 (nuclear)	Well 3½ wks. after onset.	Diminished considerably after 8 months.
Legre et al ¹² (1960)	8 mos. Female Mediterranean	1. Limited lateral neck flexion, pain at age 4 mos. and again age 6 yrs., 10 mos. 2. None reported.	1st x-ray at 8 mos. of age.	C3-C4 (nuclear)	Recovered after orthopedic treatment both times.	Still present at 6 yrs., 10 mos. No further follow-up.
Caffey ³ (1961)	22 mos. Male	1. †Fever, painful, tender neck. 2. Not stated.	Not stated.	C3-C4 C4-C5	Well in a few wks.	Gone after several mos. Was present in pre-vertebral ligaments and ventral segments of i.v.d.
	5 yrs. Male	1. †Fever, painful, tender neck. 2. Not stated.	Not stated.	C3-C4	Well in a few wks.	Gone after several mos. Was present in ventral segment of i.v.d.
Sigman and Silverstein (1961)	8-11/12 yrs. White Male	1. Severe, recurrent occipital headache and upper post. neck ache for 2 wks. Began 3-5 hrs. after batting hard-pitched baseball. Afebrile. Myopia noted at exam. 2. Urinalysis negative.	Calcifications preceded symptoms by 2½ yrs. plus.	C3-C4 C5-C6 (nuclear)	Well after wearing corrective glasses for myopia for several days.	No change 1 yr. later. Accumulated total of 3½ yrs.

REPORTED CASES OF CALCIFICATION OF NON-CERVICAL INTERVERTEBRAL DISKS IN CHILDREN

Author and Year	Age, Sex, and Race of Patient	1. Signs and Symptoms 2. Laboratory Findings	Time Relationship of Symptoms and Disk Calcification	Disks Involved	Time of Clinical Recovery	Duration of Calcification
Baron ² (1924)	12 yrs. Male	1. †Influenza-like; fever; backache; sudden onset; marked kyphosis. 2. WBC of 12,000 with relative lymphocytosis; Mantoux & Wassermann tests negative; sed. rate of 32 mm. per hour.	1st x-ray made 18 days after onset.	T12-L1 L1-L2 (nuclear)	Pain and fever gone in few days; completely well 4 wks. after onset.	Slightly larger 4 mos. after onset; disappeared 1 yr. after onset.
Kohlmann ¹⁰ (1931)	12 yrs. Male	1. *Backache after calisthenics; tenderness over spinous processes of upper thoracic spine. 2. No lab reports.	1st x-ray several days after onset.	T4-T5 (nuclear)	Several weeks.	Reduced after 2 mos.
Cohen et al ⁵ (1949)	6 yrs. Female White	1. Recurrent abdominal pain for three years. 2. Extensive lab testing negative. Pyelogram revealed bilateral pyelectasis.	X-ray 3 yrs. after onset. Disk problem unrelated to pain as neural distribution of former does not coincide with pain location.	T12-L1 (nuclear)	No follow-up.	No follow-up.
Silverman ²³ (1954)	13 mos. Female Negro	1. Patent ductus arteriosus; clubfoot; congenital atresia of external auditory canal; cervical spina bifida occulta. 2. Lab studies not remarkable. Urine negative for homogentisic acid.	Incidental finding, in workup of stated anomalies.	T4-T5 T11-T12 T12-L1 L1-L2 (nuclear)	Not applicable.	After 9 yrs. T4-T5 almost gone; T12-L1 increased; and L1-L2 no change. T11-T12, noted later, increased after 4 yrs.
	7 yrs. Female White	1. Incidental finding in workup for mental retardation. 2. Urine negative for homogentisic and phenylpyruvic acids.	Not applicable.	T3-T4 T4-T5 T6-T7 (nuclear)	Not applicable.	More dense after 3½ yrs.
	7½ yrs. Female White	1. Patent ductus arteriosus; right aortic arch; pain in right axilla for 1 mo. 4 yrs. after noting disk calcification. 2. Lab studies not given.	Incidental finding in cardiac workup. Dermatomes involved with stated pain correspond to 2nd and 3rd thoracic levels.	T2-T3 T3-T4 T7-T8 (nuclear)	Not applicable.	4 yrs. without change.
	5 mos. Male White	1. Incidental finding. Recurrent respiratory infections following pertussis at 6 mos. of age. 2. Urine negative for homogentisic acid.	Not applicable	T2-T3 (nuclear)	Not applicable.	Present after 7 years.
	6 yrs. Female White	1. Incidental finding. "Raund back." History of glomerulonephritis. 2. Urine negative for homogentisic acid.	Not applicable	T3-T4 T5-T6 T8-T9 T10-T11 L1-L2 (nuclear)	Not applicable.	Na follow-up.
Walker ²⁴ (1954)	10 yrs. Female	1. Pain, left hip, 10 wks. Lumbar lordosis and thoracic kyphosis. 2. None reported, except normal blood count.	1st x-ray made 10 wks. after onset.	T11-T12 T12-L1 L1-L2 (nuclear)	Several episodes far 6 yrs. after anset.	All gone after 8 yrs. Lowest disc appeared to be prolapsing into canal.
Crosett ⁷ (1955)	29 mos. Female White	1. †Acute poliomyelitis, paralytic. 2. Compatible, but not diagnostic of polio. Anemia. Urine negative for homogentisic acid.	1st film made 1 yr. after onset.	T11-T12 T12-L1 (annular and nuclear)	Acute symptoms lasted 2 wks. Residual weakness of right thigh and calf muscles.	Increased after 2 yrs.

*Trauma

†Infection

CLINICAL CONCEPTS / Continued

REPORTED CASES OF CALCIFICATION OF NON-CERVICAL INTERVERTEBRAL DISKS IN CHILDREN

Author and Year	Age, Sex, and Race of Patient	1. Signs and Symptoms 2. Laboratory Findings	Time Relationship of Symptoms and Disk Calcification	Disks Involved	Time of Clinical Recovery	Duration of Calcification
Wallman ^{2,5} (1957)	5 yrs. Female Dutch	1. Stiffness, pain af upper back. Afebrile. 2. WBC af 14,000 with 60% polys. Sed. rate normal.	1st film 1 mo. after onset.	T4-T5 T5-T6 (nuclear)	Well in 1½ mos.	Unchanged 4 mos. later.
Asadi ¹ (1959)	8 yrs. Male Negra	1. *3 days after 2 trauma episodes, developed low back pain and abdominal cramps. Sharp pain at dorsolumbar junction. 2. Usual lab studies plus C.S.F. negative. Urine negative for hamagentisic acid.	1st film made 11 days after onset.	T12-L1 (nuclear)	Well in several weeks.	Barely visible at 2 mos. follow-up.
	13 yrs. Male Negro	1. *Back pain 3 mos. preceded by lifting heavy object. Later, blow to back. 2. WBC of 14,850 with normal diff. Urinalysis and sickle cell prep. negative.	1st film made 3 mos. after onset.	T5-T6 T6-T7 (nuclear)	No follow-up.	No follow-up.
Caffey ³ (1961)	11 yrs. Female	1. Asymptomatic. 2. None given.	Not applicable.	T3-T4 T4-T5 (nuclear)	Not applicable.	Not stated.

ported cases has calcification persisted into adolescence. It should be pointed out that the computed time of duration of disk calcification in each case is not very accurate, largely because follow-up x-rays were taken at irregular intervals.

Of the 39 cases, 25 (64 per cent) had cervical disks involved. The cervical and noncervical group have differed in three respects. First, the male sex accounted for 76 per cent of the cervical group and only 35 per cent of the non-cervical. Second, whereas the trauma incidence was the same in both groups (28 per cent), signs of infection were present in 44 per cent of the cervical group and only seven per cent of the non-cervical group. Third, there was a definite tendency for the calcifications to resolve faster in the cervical group.

Summary

Thirty-nine reported cases of calcified intervertebral disks in children have been reviewed. This includes all found in the English language literature and some in the foreign literature.

Calcified intervertebral disks in childhood are usually incidental findings, of no clinical significance, which eventually disappear.

In only approximately ten per cent or less of the cases is the disappearance of symptoms followed sufficiently closely by the disappearance of calcifica-

tion to suggest that the decalcification is related to the cause of the patient's symptoms.

A case of cervical disk calcification in an eight year old child is reported, in which the calcification is clearly proved to be an incidental finding. The calcifications were present on a routine chest film 2½ years prior to symptoms and are still present a year after symptoms have disappeared.

It is suggested that the cervical area be more closely scrutinized on chest roentgenograms in childhood to obtain a truer incidence of cervical disk calcification in childhood.

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WOMEN'S AUXILIARY PLANS 39TH ANNUAL CONVENTION

A special program for all doctors' wives—featuring a report on current affairs in the nation's capital and tips on "guarding your husband's health"—will be presented during the 39th annual convention of the Woman's Auxiliary to the American Medical Association.

More than 2,000 Auxiliary members and other physicians' wives are expected to attend the convention to be held in conjunction with the AMA annual meeting June 24-28 in Chicago. Auxiliary headquarters will be the Hotel Pick-Congress.

The Auxiliary's House of Delegates will convene Monday morning, June 25 and will adjourn Wednesday, June 27. Meetings will be devoted to reports and discussions of Auxiliary activities including civil defense, legislation, community service, health careers, rural health, safety and mental health.

Sen. Everett M. Dirksen of Illinois and a leading medical authority will be featured speaker at special programs for all doctors' wives Tuesday and Wednesday mornings prior to the delegates' sessions.

The annual tea honoring the president, Mrs. Harlan English of Danville, Ill., and the president-elect, Mrs. William G. Thuss of Birmingham, Ala., will be held Monday afternoon.

National past presidents of the Auxiliary will be honored at Tuesday's luncheon commemorating the

Auxiliary's 40th anniversary. Guest speakers will be Drs. Leonard Larson and George Fister, AMA president and president-elect. The Auxiliary will also announce its annual contribution to the country's medical schools through the American Medical Education Foundation at this luncheon.

A postconvention workshop and planning session for 1962-63 national officers and chairmen will be held Thursday morning, June 28. Dr. Ernest B. Howard, AMA assistant executive vice president, will discuss highlights of the AMA House of Delegates meeting.

For the first time, Auxiliary members will have an opportunity to display their original works of art in a special Auxiliary Art Exhibit. Awards will be given in four categories—oils, watercolors, drawings and sculpture.

A full schedule of sightseeing tours, coke parties, swimming parties and other activities will be arranged throughout the week for the teen-age members of AMA families.

All Auxiliary members, their guests and guests of physicians attending the AMA annual meeting may participate in the social functions and attend the Auxiliary general meetings.

Local arrangements are under the direction of Mrs. Richard E. Westland, chairman, and Mrs. Joseph A. Cari, vice chairman, both of Chicago.

STROKE FILM AVAILABLE

A new professional film on strokes, which stresses the need for accurate differential diagnosis because of therapeutic advances in the field, has been produced by the American Heart Association and its affiliates.

Entitled "Cerebral Vascular Diseases: The Challenge of Diagnosis," it presents three case histories involving cerebral thrombosis, hemorrhage and embolus, and de-

picts methods for proper diagnosis in each case.

The color film runs approximately 30 minutes and is available for purchase or loan from the Georgia Heart Association, 58 Baltimore Pl., N.W., Atlanta 8, Ga., or from the American Heart Association, 44 East 23rd St., New York 10, N. Y.

REDUCING EMOTIONAL TRAUMA FROM ELECTIVE SURGERY OF CHILDREN

Martha S. McCranie, M.D., *Augusta*

- *In the child who has adjusted poorly to life's stresses, psychiatric help at the time of elective surgery is frequently rewarding.*

IN THE PAST 25 YEARS strides have been made in the recognition of emotional disturbances in childhood, the treatment of those children disturbed, and in the prevention of unnecessary emotional trauma of those children who are subjected to potentially traumatic situations.

Documentation of the possible emotionally traumatic effect of hospitalization and surgery in childhood is extensive in medical literature. From many countries have come reports from hospitals where personnel have been concerned with evaluating the sources of this difficulty and with instrumenting effective remedial action based on the observations made.

Methods of Approach

This paper presents a composite summary of various actions which can be taken by a hospital staff to reduce the emotional trauma of children hospitalized for elective surgery. It does not go into the theories behind this action nor into the statistics which validate the reduction of trauma in the children where such measures are used. Adaptations of the techniques described in this paper can be made by the basic team (pediatrician, EENT, anesthetist, nurse) of any hospital that is interested in making use of them.

For staff members to use these techniques it is a *sine qua non* that the persons employing them be individuals who are sincerely and warmly interested in both the psyche and soma of the child. They must have a minimum of negative or destructive

tendencies toward people in general and toward children specifically.

The psychological preparation of a child for elective surgery, begins when the doctor decides that an operation is necessary. It is a continuous process which does not end until long after the termination of hospitalization for the procedure. It includes several phases: (1) the doctor's explanation to the parents of the necessity for the procedure and his support to them as he informs them of the many things they need or want to know about it; (2) the parents' and the doctors' explanation of the necessity of this procedure to the child and their acceptance of the child's need to react to this necessity for an unknown experience in an unfamiliar place by displaying behavior commonly thought of as undesirable; (3) the doctor's choice of time for the procedure based on the child's emotional state and his age, as well as his physical status; (4) the modification of hospital procedures to meet the needs of the child; and (5) post hospital visit aimed at assessing the behavioral status as well as the physical status of the child with subsequent institution of whatever corrective measures are necessary for either condition.

When the pediatrician determines from the physical status of the child that the child needs referral to another specialist for confirmation of the need for operative procedures, he takes into account several factors of importance in the child's emotional state. (1) If his patient is under three years of age, the pediatrician uses every possible conservative means to enable postponement of elective surgery. Because the younger child's integrity is dependent on the continued emotional support of his parents, especially in times of stress, about 50 per

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cent of the children under three years of age who are separated from their trusted parents and familiar environment which hospitalization necessarily entails have severe and prolonged emotional sequelae as a result of that experience. When the physical condition of the child under three is such that surgery cannot be postponed, the emotional trauma to the child because of the hospitalization can be somewhat reduced by (1) the encouragement of the participation of the mother in the ward care of the child, and (2) the assigning of one nurse to relate individually as a substitute mother to that child whose mother is unable to be present.

Recent Life Experiences

(2) A second factor of psychological importance which the pediatrician determines is whether the child has been through recent life experiences which are not integrated. The pediatrician's knowledge of the recent birth of a sibling, recent loss of a parent from sickness, death or divorce, or the change of residence of the child's family will be sufficient to warrant his postponing an elective operation until a later date. Just as a sore throat from any pathogen renders the child's physical condition too vulnerable to carry out a T & A, so a child's emotional state of disequilibrium from whatever cause makes him emotionally vulnerable to a far greater degree.

Specialized Psychiatric Help

(3) The pediatrician will consider requesting specialized psychiatric help to sustain or give treatment to the neurotic child who has demonstrated through the years a minimal ability to adjust to the usual life stresses and for that child who has been traumatized already by a poor parent-child relationship. For it is these children who constitute the major portion of the ten-20 per cent of children undergoing elective surgical procedures who show evidence of residual emotional trauma even though an understanding staff employs recognized, helpful techniques during the child's hospitalization and with the operative procedure. Such a chronic emotionally damaged child and his need for specialized psychiatric help at the time of the stress of surgery can be compared to a child with heart damage who will need the help of a cardiologist at the time the heart must bear the additional stress imposed by surgery.

With his referral of the child to the surgeon, the pediatrician gives details of the child's physical status and his emotional readiness for surgery.

The surgeon confirms these findings.

Role of Parents

(1) He then *explains to the parents* the necessity of the operative procedure, the positive results to

the child which he expects to occur as a result of the procedure, and the general details of what hospitalization for the procedure will involve. He has available for the parents' use additional time in which they may ask questions. He recognizes that the parents have anxiety and fear about this unknown experience for their child. He accepts this feeling of the parents as well as the sometimes seemingly unnecessary questions which the parents ask because of this feeling. The surgeon answers questions truthfully, factually, and in terms the layman can understand.

Explanation to Child

(2) The surgeon next *explains to the child* in simple terms consistent with the child's ability to understand what his, the surgeon's role is, what is to be done and why it is necessary. He mentions the uncomfortable aspects of the procedure as well as the more positive end results. He asks the child general questions about his knowledge of the organ in question, correcting the child's fantasies by a simple statement of what is actually true. He attempts to find out the child's fantasies about operations in general, again correcting misinterpretations all children have. He gives the child a book about "Going to the Hospital." The surgeon explains what is to be done even though the child says nothing and gives no immediate evidence that he is listening. Frequently the child later repeats to other persons the very same statements the surgeon made to him, indicating that he not only heard what was said, but that it had real helpful meaning to him.

Hospitalization

(3) Several days ahead of the date set for hospitalization, the parents inform the child of this. They read about "Going to the Hospital." Further questions which the parents have can be answered by a telephone communication with the surgeon's office. The question of what personal effects—toys, clothes, pajamas, tooth brush—the child will need or may take to the hospital are of importance. He is encouraged to take a favorite article and is allowed to use as many of his personal possessions as is possible. The ward clothing is explained, the type bed the child will have, and the general nature of the ward.

Modification of various hospital procedures is helpful on children's wards if emotional trauma to the child is to be kept to a minimum.

Admission Procedures

1. *Admission procedures* can be modified so that the separation of the parent and child occurs gradually, after the parent has had a chance to see that the child is in care of persons who are interested in the child, and who understand and accept the

EMOTIONAL TRAUMA / McCranie

child. One way in which this can be accomplished is for the same nurse to accompany the parent and child through the admission procedure, take them to and show them about the ward and introduce them to other children and personnel on the ward. The nurse and mother fill out a questionnaire which tells of the personal habits and routine of the child so that hospital personnel can know what the child is accustomed to at home. The mother may assist the child with his bath and help as he gets into hospital attire.

As the parents leave, the nurse tries to divert the child to activities of fun available on the ward so that the parent feels free to go. The nurse emphasizes when the parent will return.

Doctor and nurse accept the child's feeling of confusion about the strange surroundings of the hospital. They recognize that the anxiety about this and being left by the parent may cause the child to act in one of several ways: Cry, withdraw, become aggressive, bossy, etc. The doctor or nurse may comment on the fact that they know it is difficult to be in the hospital, that they understand most children do not like to remain and had rather be at home, but that it is a temporary necessity in order to improve the child's state of health.

Ward Procedures

(2) Certain *ward procedures* may be altered to eliminate unnecessary routines, and to avoid the more distressing aspects of other routines. Temperature needs to be taken only twice before surgery. It should be taken by the oral or under-arm method rather than by rectal thermometer. The minimum use of needles is indicated. The number for a child having a T & A has been lowered to two (one for blood tests and one for administration of atropine) by some hospitals. The doctor explains each procedure truthfully, indicating why it is necessary. Again he accepts the child's fear of the procedure in spite of the explanation (and even because of it) and the child's need to react to this fear. He gives the child some control over the situation by asking him to participate in some way, i.e. hold the hand of a nurse and squeeze when it hurts, or, watch how the blood goes up the small tube. At the completion of each procedure the doctor or nurse remains with the child a few minutes to allow the child to gain control of himself once more. The child does this with the knowledge that the adult understands it is not easy for the child and that the adult respects him in spite of fearful behavior he may have shown.

Chance Remarks

(3) Commonly used friendly but teasing remarks

to a crying child, such as "Are you going to act like a baby?" or to a non-talkative child, "Has the cat got your tongue?" should be replaced by the comment that it is difficult to be away in a strange place and it is natural to feel and act the way the child does. The temporary nature of the hospitalization is stressed. Ward rounds with large groups hovering over the bed of one child, mumbled talk about any patient, and the performance of painful procedures on one child in the presence of another are, of course, *verboden*.

Anesthesia

(4) Preparation for anesthesia may be done in one of several ways, all of which are aimed at reducing the anxiety of the child as well as producing conditions favorable to an easy induction and sedation while surgery is performed. Psychological means combined with pharmacologic ones, have been used to obviate the anxiety of the child. The anesthetist who is to give the anesthesia visits the child the night prior to the scheduled operation. He describes how the doctors, nurses, and the anesthetist will be dressed in the operating room. He lets the child hold and smell the mask, telling the child about the peculiar smell it will have and the funny feeling the child will experience as he goes to sleep temporarily so the operation can be performed. He lets the child know that he will feel uncomfortable when he awakens. He is told who will be present when he awakens. As the events described by the anesthetist come to pass the following morning, the child sees that he can trust the anesthetist. He is then ready to hold the mask over his face with an occasional word of encouragement from the anesthetist, or sometimes a slight reinforcement from the anesthetist's hand.

Play Supervision

(5) In hospitals which have them, *play rooms* are helpful in providing a favorable outlet for the anxiety and aggression of children who are hospitalized. Here the "play supervisor" (nurse, social worker, or other person qualified for this job) helps the child to act out his aggressive feelings. The child becomes the doctor or nurse who performs the operation or gives the shot. In this manner of play the child is in control of the situation to which he has been passively exposed. This helps him to handle the anxiety felt in the real situation. Other play materials, clay, art, etc., are used by children to assist in accomplishing the same purpose. The play supervisor talks with the child about the feelings he has and helps the child express verbally what his play tells.

Several children may be seen in group activity in the play room. Here, encouragement of group dis-

cussion and role-playing activities by the play supervisor is effective in helping relieve the children's anxiety.

Discharge from Hospital

(6) At the time of discharge the doctor allows time for a talk with the parent. The parent may wish to ask questions about what to expect from the child at home, what to allow the child to do, and when to return. Written as well as verbal answers are appreciated by the parent who sometimes does not hear what is said or cannot think what she needs to know due to a still high level of anxiety. The doctor mentions the course of physical restitution the child will have. He also informs the parent of the usual ten day to two week period when unusual behavior (regressive tendencies, nightmares, eating difficulties, increased dependency, etc.) may be expected from the child.

Follow Up Visit

(7) Follow-up visit one to three months later is helpful for evaluation of the child's physical status and for questioning about adverse behavior. The parent, if given a few minutes of the doctor's time, often uses this interview to talk more freely about what the whole experience of the child's surgery meant to the child, the parents, and others in the family. The surgeon accepts the need of the parent to discuss these things, recognizing it is possible for the parent to do so now because of lessened anxiety when the surgeon has carried out successfully the anticipated and feared procedure on their child.

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AMERICAN HEART ASSOCIATION RELEASES FILM

CEREBRAL VASCULAR DISEASE: THE CHALLENGE OF DIAGNOSIS is the title of a new medical teaching film released by the American Heart Association.

It is a 30-minute, 16mm, color, sound film and was produced for the American Heart Association by the Churchill-Wexler Film Productions.

The film uses a combination of live action and animated diagrams to illustrate the importance of accurate differential diagnosis regarding the etiology of a

stroke. Three case histories are used as illustrations of thrombosis, hemorrhage, and embolism.

This film is a companion film to **CEREBRAL VASCULAR DISEASE: THE CHALLENGE OF MANAGEMENT**.

Both are available for loan on request to the Georgia Heart Association, 58 Baltimore Place, N.W., Atlanta 8, Georgia.

The film may also be purchased or rented for extended use.

SLIPPED CAPITAL FEMORAL EPIPHYSIS

Floyd E. Bliven, Jr., M.D., *Augusta*

- ***Physical examination in this condition almost invariably reveals limited internal rotation, limited flexion and limited abduction.***

LIMP OR A CHANGE in walking pattern in early adolescence is a signal of a slipped capital femoral epiphysis. The course of the disease is often so insidious that signs of hip deformity escape recognition until joint changes are well established. It is now recognized that adolescent coxa vara is more frequent and a more severe disease in Negro patients.

The records of patients treated by the orthopedic consultant staff of the Crippled Children's Service Clinics in Georgia have been reviewed for a five-year period. This preliminary report of certain aspects of slipped capital femoral epiphysis in Negroes emphasizes the classically described features of this disease. The degenerative changes of femur and acetabulum usually encountered in later years appear very rapidly in the Negro, often within months of clinical onset.

Incidence

Predicting from the incidence of the disease in North Europe, the recognition of 20 or 25 new cases for the 1955-1960 period would be expected in Georgia. In this period 125 cases have been registered in the Crippled Children's Service of which 100 are Negro patients. Further population data suggests an actual incidence in Georgia of about 25 cases per 100,000 population in the ten-20 year age group. A racial difference is definite with the disease about five times as common in Negroes.

The discreet age interval in which slipping of the capital femoral epiphysis occurs coincides with the last period of rapid bone growth, and the development of sexual maturity. The most frequent age for onset in girls is 11, 12 or 13 years and in boys

14 to 17 years of age. In the Negro, onset may occur a year earlier.

As one compares the racial groups as to the side affected there is little difference; the left is more commonly involved than the right. There does seem to be a significant likelihood of both hips being affected. In the Caucasian, bilateral involvement is reported in 20 per cent or 25 per cent of patients but both hips are involved in 1/3 of Negro patients.

Associated Factors

As in Caucasians, slipped epiphysis occurs twice as frequently in males. In this series over 1/3 differed from the average weight pattern, either being overweight, often excessively obese or described as tall, slender individuals. The actual cause of slipping of the femoral epiphysis is unknown but it is the epiphysis which may most readily be displaced by an excessive shearing force such as applied by torsional stress. Possibly many factors are associated: The intensive physical activity of this age, imbalance between growth hormone and the sex hormones, and the mechanical factors involved in excessive weight or insufficient muscle strength.

A history of injury is usually obtained; however, the injury has not brought the patient to a physician. An exception is the patient disabled by complete displacement of the epiphysis. In these instances the diagnosis of fracture of the femoral neck has been made and the hip treated as in the adult by hip pinning. The most common less severe injury has followed a fall from a bike or a fall playing basketball; in both cases the affected hip usually bears a sudden external rotation force.

Over many years, examinations have been made of the hip joint and of the femur in various stages of the disease. A characteristic of early appearance

is synovial inflammation and thickening. The cartilage plate may show varying degrees of disorganization and repair or replacement of growing cartilage with fibrous scar. As the epiphysis is displaced, distortion of the femoral neck occurs as the gap produced is filled in with new bone. In the late disease two patterns of joint pathology are found. The more common comprises all the changes associated with osteoarthritis or traumatic arthritis with proliferation of bone spurs, thinning of the cartilage and cystic changes in bone being characteristic. The other and more severe disturbance because of its inexorable degenerative course, results from avascularity of the femoral head, the final loss being destruction of the head and obliteration of the joint space associated with loss of joint function.

Later Symptoms

If the injury is not sufficient to bring the patient to his physician, what later symptoms lead to diagnosis? In most, it was limp. A limp transient and disappearing with short intervals of rest was often disregarded until more persistent or associated with pain or limitation of hip motion. Although the characteristic pain of slipped capital epiphysis is said to be knee or anterior thigh pain, in this group pain in the hip or even in the groin was more frequent. It was surprising how few patients with limitation of hip motion complained of stiffness although falling, stumbling or not walking right were mentioned as early complaints.

The findings on physical examination were almost invariably the triad of limited internal rotation, limited flexion and limited abduction. In half, external rotation contracture was found, this sometimes very severe and the major cause of the awkward gait. When one hip was involved shortening was prominent. Atrophy of the thigh was not often found.

X-Ray Diagnosis

X-rays establish the diagnosis of slipped capital femoral epiphysis. An anteroposterior view film of the pelvis to include both hips with the femurs in neutral position and then in the frog-leg lateral position will demonstrate the displacement. The deformity of posterior and inferior displacement of the head may be visible only in the lateral view. In the Negro patient, joint space may be narrowed even in the original diagnostic film. The deformity should be described both as to the displacement of the head from the neck in comparison to the diameter of the neck, and also its angulation from the normal position of the head on the neck.

It is in the results of treatment that the difference of slipped capital epiphysis as a disease in Negro

and Caucasians becomes manifest. The management of slipped epiphysis is based on the amount of displacement. With early recognition, fixation of the epiphysis in situ by threaded pins or a three flanged nail prevents further displacement and is associated with a good functional hip. When the displacement or angulation is moderate the surgeon is faced with a dilemma. No correction may leave articular surfaces unmatched and the joint subject to a mechanical disadvantage in weight bearing.

Degenerative articular changes may be delayed but are inevitable later. On the other hand if the surgeon decides to correct malposition by manipulation, he may injure the precarious blood supply of the epiphysis which is carried almost alone by the branches of the medial femoral circumflex artery across the posterior and inferior aspect of the femoral neck. The consequence then is avascular necrosis and eventual loss of the femoral head and the articular cartilage of the joint. Traction and gentle manipulation of the hip under anesthesia will, if diagnosis is made early, correct the displacement without interfering with the blood supply and will assure a functional hip. Unfortunately, diagnosis is often made months after initial displacement. The slipping will have progressed and simultaneously new bone filled in the metaphyseal gap so that reduction may not be possible.

Results of Osteotomy

In these cases with a fixed deformity and particularly with marked displacement results are uniformly poor. Correction of the deformity by osteotomy of the femoral neck is associated with a very high rate of avascular necrosis. Correction of the position of the extremity by osteotomy at either trochanteric or subtrochanteric level may not achieve re-alignment of the articular weight bearing surface of the femoral head. In this review, the results of different methods of treatment have been compared with end-results of other predominantly Caucasian series. The overall result is remarkably poor for all types of treatment in the Negro patient unless almost normal anatomical relationship can be restored without impairing the femoral blood supply.

Early Symptoms

Better management of this severe crippling disease requires early detection. Limp is the indication for careful examination of back and lower extremity. If hip motion is limited then X-rays should be obtained. Moderate deformity may be missed if lateral views are not included. The objectives of treatment are:

1. Restoration of weight bearing alignment of the femoral head.

SLIPPED CAPITAL FEMORAL EPIPHYSIS / Bliven

2. Fusion of the epiphysis.
3. Protection of the epiphyseal blood supply.

When treatment is compromised, osteoarthritis and avascular necrosis will invariably lead to the loss of hip function. In the Negro, this course is rapid ending in ankylosis within months, in Caucasians, the course may develop over many years.

Talmadge Memorial Hospital

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WHAM CONFERENCE HELD AT MAG

On March 21, 1962, the Legislative Board, working closely with the Woman's Auxiliary to the Medical Association of Georgia, sponsored a WHAM, "Women Help American Medicine" Conference at the MAG Headquarters Building in Atlanta.

WHAM, a current project of the Woman's Auxiliary to the AMA, is designed to enlist the full and enthusiastic support of physicians' wives in the campaign to defeat the King-Anderson Bills. Approximately 60 doctors' wives attended this one day meeting.

The highlight of this meeting was a rousing "pep talk" from Congressman Durwood G. Hall "piped in" via telephone loud speaker from the Congressman's office in Washington, D. C. Congressman Hall was selected for this assignment because of his keen insight into the problems attending medical care of the aged. Prior to being elected to Congress in 1961, Congressman Hall was engaged in the private practice of medicine in Springfield, Missouri.

The central theme of Dr. Hall's address was that we can win this fight against social security medicine IF: if everyone, and the ladies in particular, will pitch in and assume their full share of the burden in opposing this iniquitous piece of legislation; if we all will make every effort to inform the people of the true facts and the real implications and ramifications of the King Bill; and, if we continue to present a united front and refuse to permit the opposition to segment us into opposing groups within our own ranks.

In addition to Congressman Hall, two outstanding speakers from the Legislative Department of the American Medical Association were on hand to help the members of the Auxiliary get a better understanding of the total problem and to outline programs which they could adopt to help defeat the King-Anderson Bills.

Also present to acquaint the members of the Auxiliary with the WHAM Campaign, as it is being conducted in other Southeastern States, was Mrs. Roy A. Douglas, Area Legislative Chairman of the Women's Auxiliary to the AMA. Mrs. Douglas, who hails from Huntingdon, Tennessee, remarked following this meeting that the intense interest displayed and the depth, sincerity and quality of the questions asked during the Question and Answer period of the program was the best she has encountered at any WHAM meeting she



Left to right: John T. Mauldin, M.D., Medical Director for Georgia's Medical Assistance to the Aged; Mrs. Roy A. Douglas, Area Legislative Chairman of the Women's Auxiliary to the A.M.A.; Bernard Harrison and Lee Ann Elliott of the A.M.A. Legislative Department.

had attended. This unquestionably reflects the interest and concern of the Auxiliary to MAG which this problem has manifested among all who are acquainted with it.

Organized medicine and all who have joined it in its fight to preserve free enterprise in medicine have been accused many times of being negative. This unfounded charge is usually made by those who seek to cast organized medicine in the role of one who is opposed to all change. However, the most far reaching piece of medical legislation to be enacted in a good long time was the Kerr-Mills Law, which, of course, doctors, both individually and in organized groups, have supported throughout. Against this "cult of the negative" accusation the WHAM Conference included on its program a frank and open discussion of the Kerr-Mills program in Georgia.

MAG Secretary, John T. Mauldin, who also doubles as Medical Director for the Kerr-Mills program, discussed the implementation of Georgia's MAA (Kerr-Mills Law) program. His discussion centered around an explanation of what it is, how it operates, why it is set up the way it is, and what we may expect from this program in the future.

THE ROLE OF THE FAMILY PHYSICIAN IN REHABILITATION

Fred Simonton, M.D., *Chickamauga*

THE NEED TO REACH practicing physicians with newer concepts and techniques in medicine has long been recognized but the role of the family physician in the rehabilitation of patients suffering with chronic physical impairment has been relatively neglected. A more imaginative effort to remedy this situation will involve a close study and a more efficient utilization of all the existing complex of health and welfare agencies in the community, including both the official agencies and the voluntary organizations. A study of the current utilization of these resources in any community will show that in most communities, there is an ignorance of what is available in the form of certain skills and services. In other communities, there will be considerable duplication of services and in others, still, a high degree of fragmentation. In all communities can be found many persons with leisure time, noble and Christian intentions and a willingness to serve the cause of rehabilitation of their neighbors. These, together with such official agencies as those of public health and welfare, offer physicians a new opportunity to provide at minimum cost to the patient, most of the care and rehabilitation which he needs, particularly if there is no reason for the patient to be institutionalized. The physician is the logical person to provide the leadership in organizing and utilizing these community resources and in bringing them to bear on the needs of his patients.

In the United States, there are an estimated 70 million persons who are affected by some chronic condition. Some 17 million of these, almost ten per cent of the population, are suffering some physical impairment or have some limitation in their capacity to engage in activity. More than a third of these have serious ambulatory impairment. The higher proportion of disability is among those who are above the age of 45. The success achieved

in controlling communicable diseases and acute infections as causing premature death is causing thousands of people to live to maturity and old age; however, it is significant to note that this is a mixed blessing because many of those who survive, become the victims of chronic diseases and long-term illness which requires extended care during the part of life when their earnings are greatly reduced or non-existent. This is a problem which will continue to grow. In the absence of specific means at the present time to prevent or cure many chronic diseases, new techniques of care must be developed to restore the functional capacity of the affected individual as well as to relieve his symptoms.

Preventive Measures

Often, the initiation of preventive measures early in the illness of a patient will prevent or minimize the need for special rehabilitation services and facilities which are both expensive and time consuming and in many instances, impossible to obtain. Too often, patients do not reach the rehabilitation centers until long after they have suffered substantial impairment and disability. More than two years have elapsed, in many instances, between the onset of the disease and the admission of the patient to a rehabilitation facility. This delay greatly increases the cost and the time which is required to help the patient. Often the case is complicated by bad sores, contractions, frozen joints, limited atrophy and incontinence. The case may be further complicated by psychological and emotional disturbances, requiring the services of a skilled psychiatrist. Much can be done to help the patient who has had a stroke, even if he cannot be taken to a hospital. The doctor should see that this help is begun immediately. He may arrange for a nurse or a physical therapist to come to the home and care for the patient or to instruct the family or

other volunteer workers what can be done and how to do it. Such a program of management determined by the physician, with some instructions both oral and written, may rescue the patient from a long illness with its attendant unhappiness and the need for more extended rehabilitation. The value of these procedures is just as great as that of surgical intervention, yet the cost to the patient and the limited professional time required of the doctor, is but a fraction of the requirements if the treatment were delayed for several months. The doctor's responsibility to the patient begins when the doctor first sees the patient with a disease or an injury which may result in functional impairment and continues as long as the patient needs medical and other supportive services to maintain his maximum function. The procedural effectiveness of rehabilitation services which a patient receives is unlike the more conventional measures of treatment of disease. In the former, the physician is largely in the role of functional management. His work involves the supervision and direction of other professional persons in caring for the patient who is disabled. These professional groups may include occupational and speech therapists, nutritionists, medical social workers and others. In some instances, members of the family of the patient may need to be trained in the performance of many of these functions which do not require professional skill and training.

Role of Physician

The role of the physician as a manager, organizer and supervisor is not new in the field of medicine. From the beginning of medical history, physicians have involved other groups and individuals in the great task of caring for the sick and injured. The pharmacist has long been delegated the responsibility of compounding and dispensing the drugs which the physician prescribes, thus giving the physician more time for examining his patients and diagnosing their ills. Similar delegations have been made to dentists, nurses, laboratory technicians and many others. In each case, it has been necessary to identify special techniques and to establish a system of training in these techniques. At the same time, these new disciplines have developed a professional jargon of their own and a "short-hand" communication system between each other and between the physician and those comprising the auxiliary professions. These provide a time-saving vehicle for relaying directions. Thus the terms "Trendelenburg's position" and "routine tracheotomy care" are convenient substitutes for laborious and detailed instructions. Similar systems of

communication need to be developed between the physician and the members of the newer ancillary disciplines for obtaining maximum use of both time and services. In the problem of rehabilitation, it is particularly necessary that we find more convenient and effective ways of communicating with the laymen. An example of such a communication tool is that prepared by the U. S. Public Health Service, Publication No. 596, entitled "Strike Back at Stroke." This brochure contains simple drawings and illustrations with step by step procedure plainly described so that most, if not all of the effort in teaching these exercises by demonstration can be transferred to the printed pages, thus saving the physician's time and the patient's expense.

Means of Restoration

Until recently, physicians have devoted their major attention to the causes, diagnosis and treatment of acute illness. However, the amount of chronic illness among aged persons is constantly increasing and there is a need to abandon the traditional attitude of passive acceptance and neglect of the chronic diseases of this group of people. There is a need to place the physical, psychological, social and vocational rehabilitation of the chronically ill on the same level with medicine and surgery for the acutely ill, and thus to restore them to the highest degree of vocational productivity and usefulness. One of the major responsibilities of a physician who has prevented the death of an extensively paralyzed patient or otherwise chronically ill person, is to restore such a patient to self-respecting citizenship by every means possible.

Prevalence of Chronic Disease

Chronic illnesses among aging persons are more prevalent than among younger groups. These include cardiovascular diseases, arthritis, cancer, orthopedic impairment, mental illness, loss of hearing, loss of vision and genitourinary diseases. Some are so completely incapacitating as to require institutional care. There are about 188,000 deaf persons in the United States, more than half of whom are over 45 years of age. Of the 2,200,000 hard of hearing, approximately 80 per cent are over 45 years of age. The totally blind persons in the nation number 350,000 of whom two-thirds are in the older age brackets. Chronic disease accounts for 80 per cent of all cases which could benefit from rehabilitation. Accidents, both occupational and in the home, account for only ten per cent. It is disease and not accidents which provides the steady backlog of incapacitation.

Physicians as humanitarians should be striving to assist in the great social endeavor of rehabilitation

of the disabled which is being made by the State-Federal program and other agencies. The goal of this program is the rehabilitation of 200,000 persons each year. The rehabilitation process requires the combined efforts of a wide variety of professional groups — physicians, physical therapists, speech pathologists, audiologists, social workers, vocational counselors and many others. Serious shortages are apparent in all of these professional fields. For example, there is a total of 8,000 practicing physical therapists in the United States at the present time and it is estimated that 5,800 more are needed in hospitals and rehabilitation centers across the country. There are only 38 approved physical therapy schools in the United States which produce 500 graduates a year. Currently, only about 300 rehabilitation counselors are being trained each year when the figure could be as high as 1,200 without producing more than could be profitably employed.

Rehabilitation Agencies

The largest public program providing rehabilitation services to disabled people in the nation is the State-Federal vocational Rehabilitation program which operates in all 50 states and in the U. S. Possessions. Under this program, older disabled people are provided the same vocational services as are furnished to others. In addition, many voluntary agencies supported by private charity, operate programs which are affiliated with the National Society for Crippled Children and Adults. They work closely with public agencies. Finally, there are a number of privately-operated nursing homes which maintain a total of 450,000 beds in the United States. These are devoted almost entirely to the aged. The average age of persons taken care of in nursing homes is 80 years and, reflecting the preponderance of females in the older age brackets, two-thirds are women.

While we have made tremendous strides in recent years in the treatment and management of disability and we know more about how to restore these people to active lives than ever before, we are confronted with a tragic paradox: We have several million disabled people in the older age brackets who constitute the largest group of disabled people in the nation and who are not receiving the services which would enable them to lead full and useful lives.

Ancillary Personnel

As we look at the mounting burdens of long-term illness and old age, and the mounting costs of care in hospitals and other institutions, we are faced with the problems of finding some alternatives to

the traditional methods of caring for these people. One alternative is to provide care for these patients in their own homes. Often this can be done adequately and satisfactorily. In such cases, the physician only makes the diagnosis and prescribes the treatment while his prescription is carried out by a number of ancillary personnel. It is significant to note the growing importance of this ancillary personnel—men and women without professional medical degrees who now deliver the nation's medical and health services. Of a total of two million in the nation, only about ten per cent are physicians. The role of this ten per cent of physicians, is coming to include that of an administrator and organizer in marshalling these supplementary services in the most effective manner. An expansion of this ancillary personnel through scholarship grants for their training, salary scale commensurate with the nature and importance of their work, and a program of public relations to attract more people to this occupation, should go far toward solving the problem of high cost of adequate care and treatment.

Costs

It is estimated that only about 20 per cent of the total cost of medical care is for the services of physicians, with 80 per cent providing the complex of other services required such as nurses, therapists, drugs and physical equipment. Most existing health insurance plans offer coverage only for hospitalization and a few other services. Such coverage does not meet the costs of medical care for long periods of illness and those involving any degree of rehabilitation. So that many families do not become hopelessly indigent in attempting to meet these costs of long-term illnesses, the medical profession must provide leadership in developing acceptable means for providing complete care for a great many more people than are now provided for. One method which offers great promise and which lies within the framework of democratic way of life, is the mobilization and organization of the latent resources of the community in providing these needs. The same charitable and humane impulses which attacked, fought and all but defeated the scourge of polio, could be harnessed anew for these purposes and with even more gratifying results.

There is no question that severely impaired or disabled patients require organized special skills, procedure and even special equipment. This does not mean however, that the general practitioner and others not trained in this special work cannot learn and apply many of the procedures which may prevent or limit disability. In fact, the majority of patients with long-term illnesses are already being

FAMILY PHYSICIAN / Simonton

treated by general practitioners and internists. There is an urgent need to help practicing physicians keep abreast of current developments in this area of medical practice.

To this end, a number of medical schools have already established departments of physical medicine and rehabilitation and such courses have been devised for the under-graduate medical student and for the training of residents. In addition, lectures, seminars and clinic sessions for physicians sponsored by the American Academy of Physical Medicine and Rehabilitation deal with the concept and methodology of rehabilitation.

The medical profession needs to establish a broader view of the objectives of the medical practice which, in addition to dealing with the symptoms of disease, includes the responsibility for functional management to prevent the onset of disease and the encouragement of low-cost and charitable local efforts to restore and rehabilitate those suffering from its disabling effects. The last is a formidable but imperative objective. If accomplished, it will do more to enhance the stature of the medical profession in the eyes of the public than anything which has happened in the current century.

16 Euclid Avenue

TENTH ANNUAL DISASTER MEDICAL CARE CONFERENCE TO BE HELD IN CHICAGO

"Community Preparedness for Emergencies" will be the theme of the 10th annual National Conference on Disaster Medical Care in Chicago, June 23.

Sponsored by the Council on National Security of the American Medical Association, the one-day meeting at the Palmer House immediately precedes the opening of AMA's 111th annual meeting.

This year's program, consisting of three sections, was developed and will be presented by the Division of Health Mobilization of the U. S. Public Health Service. The sections, all of which are related to the central theme, are:

- Means of achieving community preparedness.
- Meeting the needs of the public.
- Newer techniques designed to help meet professional needs.

The keynote address, "Preparedness at the Community Level—an Urgent Goal," will be delivered by Luther L. Terry, M.D., the surgeon general of the U. S.

The conference is expected to be attended by 500 physicians, public health officers, and civil defense personnel.

Additional information may be obtained by writing: Department of National Security, American Medical Association, 535 N. Dearborn, Chicago 10, Illinois.

NUCLEAR MEDICINE TO BE FEATURED AT AMA MEETING

The American Medical Association and the Atomic Energy Commission will be joint sponsors of a special joint meeting on Nuclear Medicine at the 111th annual meeting of the AMA at Chicago, June 24-28.

Theme of the overall annual meeting will be "Medicine in the Atomic Age." All sessions and exhibits will be concentrated in Chicago's giant new auditorium and convention hall, McCormick Place, on the shore of Lake Michigan.

"The nuclear age already has begun to bring many changes and innovations to the practice of medicine," said Dr. Samuel P. Newman of Denver, chairman of the AMA's Council on Scientific Assembly.

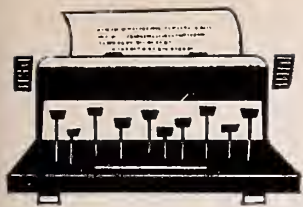
"The program of the special joint meeting at the Chicago meeting is designed to enable the physician in practice to bring his knowledge of available nuclear diagnosis and therapy up-to-date," Dr. Newman said.

Dr. Lee Edward Farr of Brookhaven National Laboratory, Upton, New York, a member of the Council on Scientific Assembly, is serving as coordinating secretary for the session on Nuclear Medicine. Participating Sections are Internal Medicine; General Surgery, and Radiology.

Another major aspect of the Chicago meeting will be a special half-day general session on Mental Health. It will be sponsored jointly by the AMA's Council's on Scientific Assembly and on Mental Health, with Dr. John E. Adams of San Francisco as coordinating secretary. Participating sections are nervous and mental diseases; general practice, and internal medicine.

A general session will be offered on Teenagers' Problems encountered in medical practice. Coordinating secretary is Dr. James L. Dennis of Oakland, Calif. Participating sections are Pediatrics; Nervous and Mental Diseases; Obstetrics and Gynecology; Urology; Dermatology, and Orthopedic Surgery.

Inflammatory and Ulcerative Diseases of the Small Intestine will be the theme of another half-day general session, under the direction of Drs. Clyde A. Stevenson of Spokane, Washington and G. Gordon McHardy of New Orleans as coordinating secretaries. Participating sections will be Radiology; General Surgery; Internal Medicine; Gastroenterology and Proctology, and Pathology and Physiology.



Studies in DeKalb County Again Remind Us of Importance of Fluoridation

MORE THAN 30 YEARS OF CAREFUL, objective evaluation of evidence collected from all over the world has shown the dental benefits of water fluoridation. Studies in Georgia communities are adding to this vast store of knowledge. The most recent report came from DeKalb County which was the first and largest system in Georgia to fluoridate.

Fluoridation of the DeKalb Water System began in 1951. Studies conducted at that time by the Dental Health Branch of the Georgia Department of Public Health, Emory University School of Dentistry, and the DeKalb County Health Department established a base-line of the prevalence of dental caries for comparison with subsequent evaluations in 1956, and in 1961. The 1961 ten-year survey involved more than 13,000 school children age six-17 years who were continuous residents in areas served by the DeKalb Water System.

A significant point was brought out in comparing the 1956 and 1961 results, i.e. the need for maintaining the fluoride concentration sufficiently high to obtain maximum benefits. During the first five years the average fluoride concentration was reported to be 0.66 parts per million; from 1956 through 1961 the average was 0.88 parts per million, which is within the range of 0.7 - 1.0 p.p.m. recommended by the State Health Department. Analysis of the data reflects the inverse relationship between the amount of dental decay and the fluoride concentration in the water supply, even in these minute quantities.

Among the six year old children, who had the benefit of fluoridated water most of their lives, the first group (1956) had 36 per cent improvement after five years of fluoridation in which the fluoride concentration was sub-optimal, compared to almost 65 per cent for the second group (1961) who con-

sumed optimal concentration of fluoride during a similar length of time.

Fluoridation of community water supplies has been endorsed and repeatedly endorsed by virtually every state and national organization competent to judge a safe and economical procedure for significant reduction in the incidence and prevalence of dental decay.

Among the six year olds the average child had 1.14 teeth attacked by decay in 1951, and 0.73 in 1956 and 0.40 in 1961. Thus there was 36 per cent less decay in 1956 than in 1951 and 64.9 per cent less in 1961 than in 1951. For all ages six-17 there was 31.1 per cent less decay in 1956 than in 1951 and 45.8 per cent less in 1961 than in 1951. The decay rates of the DeKalb County children in 1951 before fluoridation statistically, are identical with the decay rates observed in Atlanta children today.

The results of this study should again emphasize to all physicians and dentists and other health workers the importance of increasing the use of this safe and effective method as endorsed by the Medical Association of Georgia at its 103rd Annual Session in Savannah in May 1953.

Again these data demonstrate the effectiveness of safe but adequate fluoride in reducing dental caries by a factor of approximately two-thirds in children who receive it consistently from an early age. A further demonstration, again the fact that fluoride is effective to a lesser extent on older children; therefore, as a public health measure it is essential that the maximum number of children have the opportunity of having fluoridated water available at the earliest possible age.

*John H. Venable, M.D.
Director, Georgia Dept. Public Health
47 Trinity Ave., S.W.
Atlanta 3, Georgia*

What is AMPAC?

PLATO, SOME TWO THOUSAND years ago, said that one of the penalties for refusing to participate in politics is that you end up being governed by your inferiors. If you are not in active politics, the next best thing is for you to let your representatives know how you feel and think and help select the candidates who feel and think the same as you concerning free enterprise and what is best for you and your country.

AMPAC is a nationally organized committee which has not yet reached its first birthday through which you can let those who will govern you know your feelings and whereby you can find out your representatives' records, how they have voted, their feelings and philosophy, and how they can be expected to vote in the future. Doesn't Georgia need its own organization whereby it can get down to the grass roots and organize to reach each district and county medical society? I think so.

The basis of any political issue and organization is the individual vote; therefore, it is up to each individual physician to do his part and to participate in molding and preserving the government which he desires. The AMA and MAG are not allowed by federal law to do this; therefore, the AMA has set up a committee called the American Medical Political Action Committee, or AMPAC, which is legally constituted and whose Board is bound at all times to represent the will of the American men of medicine.

Purposes of AMPAC

The purposes of AMPAC are: 1) To promote and strive for the improvement of government by encouraging and stimulating physicians and others to take a more active and effective part in government affairs; 2) to encourage physicians and others to understand the nature and actions of their government in regard to important political issues, as well as the records and positions of political parties, office holders, and candidates for elective office; 3) to assist physicians and others interested in organizing for more effective political action and for carrying their civic responsibilities; 4) to do any and all things necessary or desirable for the attainment of the purposes stated above.

The AMPAC is a non-corporate body not aligned with any political party. Its organization is composed of doctors, their wives, their children, and any other interested parties who wish to participate

and help mold and preserve the government of this country to be most beneficial for all. At last this is a way whereby you as a physician can speak your mind concerning candidates for federal and other governmental offices. Why not participate while you can voluntarily rather than wait until it is too late?

Membership Requirements

Membership in AMPAC is available through your state medical political action committee or by direct application to AMPAC. This is a permanent organization. As you well know, we have seen issues brought before the legislative bodies every few years seeking to place medicine under federal control. This organization will keep posted and attempt to keep men in as elected officials who value free enterprise and the rights of the individual in this country of ours and who want to preserve our type of government, which has proven the best for all concerned.

AMPAC's membership classifications and dues are: Active, \$10.00 or more; Sustaining, \$99.00 or more; Associate, \$10.00 or more; Student, \$5.00 or more. Why not join now? Remember that in the 1960 presidential election neither candidate received a majority of the votes; as a matter of fact, victory was won by a hairline margin of 112,881 votes, less than one vote per precinct.

AMPAC will do its part. First, through education it will develop and promote such programs as analysis of voting records, review of national legislative issues, voter registration drives, and publication of related materials and information. Second, it will follow proven patterns of campaign activity. Selection of target areas will be based upon thorough analysis at the local level, review of reliable national analysis, the marginal nature of the specific district, and other pertinent factors. Support for candidates will be based upon realistic political appraisal. Third, AMPAC will coordinate its efforts with the efforts of those individuals and groups, medical and non-medical, who are actively engaged in programs designed to obtain good government.

Do your part by joining your State Committee and then help with the national AMPAC.

Milford B. Hatcher, M.D.
Macon, Georgia

Factors Relating to the Virulence of Staphylococci

EXCEPT FOR NEW antibiotics against it, nothing exciting has been discovered about the staphylococcus for some time. David Rogers, Professor of Medicine at Vanderbilt University, combining a singular familiarity with infectious disease, an original mind and a rather simple laboratory set-up is seeking answers concerning the difference between virulent and avirulent staphylococci. Both produce coagulase, both ferment mannitol and both are equally hemolytic but in a soft agar preparation mixed with serum on a glass slide he found that the avirulent type grew in a compact mass whereas the virulent variety formed a diffuse spearheaded streak. The diffuse invasive variant produced death in mice whereas the compact variety did not. Leukocytes destroyed the avirulent type in 48 minutes whereas the virulent one remained extracellularly as long as three-four hours. This suggested a surface difference in the two. By immunizing animals with the virulent type the same rapidity of phagocytosis could be induced as with the avirulent.

Next, he washed leukocytes free of serum and found that they did not phagocytize the avirulent organisms. Rabbit serum failed to restore phagocytosis whereas human serum did. Heated human serum failed as did guinea pig serum but the two together stimulated phagocytosis of the virulent

variant. Either antibody or heat labile serum factor alone could promote phagocytosis of the avirulent organism. He felt that the virulent organism was behaving like an organism with a capsule so the organisms were suspended in India ink and examined with phase microscopy. Clearly, the virulent organism had a *capsule* whereas the avirulent staphylococcus did not.

An interesting side-light is that he could immunize animals against the virulent type and the serum of this animal would cause the same response to phagocytosis that the avirulent type had. When Dr. Rogers was asked if this meant that he felt that there was some hope for vaccines in the patient with resistant staphylococcal infections he responded that he thought it possible. Man already has a very high antibody titer against non-pathogenic staphylococci but not against pathogenic variety. Dr. Rogers ventured the opinion that it was possible that the thick-walled abscesses produced by virulent staphylococci might interfere with the introduction of antigen into the general body fluids and that vaccination may prove to be of benefit in patients with abscesses. He emphasized that this was speculation and had yet to be demonstrated.

This refreshing new approach to the staphylococcus problem is commendable.

1000TH MEDICAL FILM REVIEW PUBLISHED BY JAMA

The American Medical Association's 16-year program of disseminating information on new medical motion pictures reached a coveted milestone this winter with the publication in the Journal of the AMA of the 1,000th film review.

Medical film reviews, which have been especially valuable to medical educators and program chairmen in planning for state medical society meetings and hospital staff conferences, have been appearing regularly in the Journal since February, 1946. They are widely read both in this country and abroad.

The A.M.A. maintains a film library of 1,253 prints of 268 different subjects. The library is constantly being enlarged as new films are produced. In 1961 the film library booked a total of 10,025 showings of medical motion pictures, an increase of almost 14 per cent over the previous year.

For the past six years the British Medical Association has reprinted the A.M.A.'s motion picture reviews

in its publication, "Medical and Biological Illustration." Each review contains technical data on the film, details about its availability, name of producer or author, and a description and evaluation of content. Each film is screened by a committee of physicians who are specialists in the subject being presented.

Reprints in booklet form of reviews published from 1955 through 1961 are available on request from the Department of Medical Motion Pictures and Television, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

The film program is supervised by Ralph Creer. Mr. Creer is a former director of the Medical Illustration Department of Yale University School of Medicine. He served as a major in the U.S. Army Medical Administration Corps in World War II, organizing and directing the Army's medical illustration program. He also has arranged and coordinated international medical film exhibitions in many foreign countries.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Ausbon, Wm. W.	1315 Wildwood Avenue Columbus, Ga.	Active	Muscogee
Bailey, Joseph P.	Talmadge Memorial Hosp. Augusta, Ga.	Active	Richmond
Bleich, Allan	80 Butler Street, S.E. Atlanta 3, Ga.	DE 2	Fulton
Bogges, Neil D., Jr.	204 West Waugh Street Dalton, Ga.	Active	Whitfield
Butler, Charles W., Jr.	69 Butler Street, S.E. Atlanta 3, Ga.	DE 2	Fulton
Caldwell, Wm. C.	2036½ Virginia Avenue Augusta, Ga.	Active	Richmond
Campbelle, Alexander B.	228 Cedar Hill Street Cedartown, Ga.	Active	Polk
Caplan, Gerald E.	Memorial Hosp. of Chatham County, Savannah, Ga.	Active	Georgia
Cooper, Harry A.	Box 207, St. Joseph Inf. Atlanta 3, Ga.	DE 2	Fulton
Cureton, M. K.	Walker Co. Public Health Office LaFayette, Ga.	Active	Walker Catoosa Dade
Davis, Tudor C.	942 W. Peachtree St., N.W. Atlanta 9, Ga.	Active	Fulton
Dillon, Harold T., Jr.	62 Butler Street, S.E. Atlanta 3, Ga.	Active	Fulton
Geiger, C. Leonard	Pathology Dept., VAH 4158 Peachtree Rd., N.E. Atlanta 19, Ga.	Service	Fulton
Gertler, Phillip E.	1968 Peachtree Rd., N.W. Atlanta 9, Ga.	DE 2	Fulton
Goodman, Max L.	Emory University Atlanta 22, Ga.	Active	Fulton
Harkness, James W.	Orthopaedic Dept. Talmadge Memorial Hosp. Augusta, Ga.	Active	Richmond
Harvey, Louis R.	P. O. Box 383 Sandersville, Ga.	Active	Washington
Hobby, Lovic W.	80 Butler Street, S.E. Atlanta 3, Ga.	DE 2	Fulton
Hornberger, R. B.	300 Boulevard, N.E. Atlanta 12, Ga.	Active	Fulton
Johnson, C. M.	P. O. Box 106 Eastman, Ga.	Active	Ocmulgee
Laramore, Herbert F.	State Health Dept. 47 Trinity Ave., S.W. Atlanta 3, Ga.	Associate	Fulton
Leonardy, John G.	915 Castle Falls Drive, N.E. Atlanta, Ga.	Active	Fulton

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Maden, William L., Jr.	Emory University Clinic Atlanta 22, Ga.	Active	Fulton
McCellan, Clara A.	1301 Marie Ave., N.W. Forest Park, Ga.	Active	Fulton
McCellan, M. M., Jr.	Fort McPherson, Ga.	Active	Fulton
McClure, Cuvier D.	U. S. Dept. of Public Health, 8th Street Columbus, Ga.	Service	Muscogee
McNair, Hal H.	Reidsville, Ga.	Active	Southeast Georgia
Meltzer, Harold D.	Dept. of Pathology Emory University Hosp. Atlanta 22, Ga.	DE 2	Fulton
Metts, Betty Hogan	110 W. Gaston Street Savannah, Ga.	Active	Georgia
Metts, James C., Jr.	110 W. Gaston Street Savannah, Ga.	Active	Georgia
Moore, Perry	Reidsville, Ga.	Active	Southeast Georgia
Newberry, Dan C.	Suite 229, Doctors Bldg. Columbus, Ga.	Active	Muscogee
Portman, Bernard M.	5002 Paulson Street Savannah, Ga.	Active	Georgia
Reeves, J. Lane	701 Abercorn Street Savannah, Ga.	Active	Georgia
Shuffstall, R. M.	Laboratory, The Medical Center, Columbus, Ga.	Active	Muscogee
Smith, Richard B.	3158 Maple Dr., N.E. Atlanta 5, Ga.	Active	Fulton
Stein, J. D.	229 Doctors Bldg. Columbus, Ga.	Active	Muscogee
Stergus, Ingrid	Batley State Hospital Rome, Ga.	Active	Floyd
Stewart, Joe A.	W. Washington Street Summerville, Ga.	Active	Chattooga
Terrell, Guy K.	1 Thomas Road Fort Oglethorpe, Ga.	Active	Walker-Catoosa Dade
Thomas, J. Lowell	708 Crossgate Road Port Wentworth, Ga.	Active	Georgia
Ward, Richard S.	Dept. of Psychiatry Emory University Atlanta 22, Ga.	Active	Fulton
White, Perry M.	545 Baptist Professional Building Atlanta, Ga.	Active	Fulton
Wyatt, Barbara	5 Professional Court Rome, Ga.	Active	Floyd

1962-63 CALENDAR OF MEETINGS

State

June 4-9—Postgraduate course in Six Days of Cardiology, Emory University School of Medicine, Atlanta.

May 5-8—Annual Session, Medical Association of Georgia, Jekyll Island.

Regional

September 14-15—American College of Obstetricians and Gynecologists, District VII, Little Rock, Arkansas.

September 18-20—Kentucky State Medical Association, Brown Hotel, Louisville, Kentucky.

September 24-25—Tennessee Valley Medical Assembly, Chattanooga, Tennessee.

October 4-6—American College of Obstetricians and Gynecologists, District IV, Barringer Hotel, Charlotte, North Carolina.

October 14-17—Medical Society of Virginia, Sheraton-Park Hotel, Washington, D. C.

November 12-15—Southern Medical Association, Hotel Fontainebleau, Miami Beach, Fla.

November 15-17—Southeastern States Cancer Seminar, George Washington Hotel, West Palm Beach, Fla.

National

May 28-30—American Ophthalmological Society, The Homestead, Hot Springs, Va.

May 29-June 2—American College of Cardiology, Denver Hilton Hotel, Denver, Colo.

June 4-22—Forty-seventh Session of the Trudeau School of Tuberculosis, Saranac Lake, New York.

June 18-20—American Geriatrics Society, Palmer House, Chicago, Illinois.

June 18-20—American Neurological Association, Claridge Hotel, Atlantic City, New Jersey.

June 19-21—San Diego Symposium on Biomedical Engineering, Stardust Motel, San Diego, California.

June 21-25—American College of Chest Physicians, Morrison Hotel, Chicago, Illinois.

June 21-24—American Therapeutic Society, McCormick Place, Chicago, Illinois.

June 23-24—American Diabetes Associations, Inc., The Conrad Hilton, Chicago, Illinois.

June 23—American Academy of Tuberculosis Physicians, The Palmer House, Chicago, Illinois.

June 24-28—American Medical Association Annual Session, Chicago.

June 24—Society for Vascular Surgery, Conrad Hilton Hotel, Chicago.

June 27-30—Society of Nuclear Medicine Baker Hotel, Dallas, Tex.

July 9-13—Eleventh Annual Symposium for General Practitioners on Tuberculosis and Other Pulmonary Diseases, Saranac Lake, N. Y.

July 23-27—Postgraduate course in Cardiopulmonary Problems in Children, Edgewater Beach Hotel, Chicago.

August 26-27—American Academy of Physical Medicine and Rehabilitation, Hotel Commodore, New York City.

August 30 - September 8—American Society of Clinical Pathologists, Palmer House, Chicago, Illinois.

September 1-4—College of American Pathologists, Palmer House, Chicago, Illinois.

September 6-8—American Association of Obstetricians and Gynecologists, The Homestead, Hot Springs, Virginia.

September 17-20—American Hospital Association, Chicago.

September 17-November 9—Occupational Medicine, postgraduate course, New York University, New York City.

September 17-21—American College of Chest Physicians postgraduate course, Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, Warwick Hotel, Philadelphia.

October 2-5—American Roentgen Ray Society, Shoreham Hotel, Washington, D. C.

October 4-6—American Medical Association First National Congress on Mental Illness and Health, Palmer House, Chicago.

October 15-19—American College of Surgeons, Clinical Congress, Atlantic City, New Jersey.

October 17-18—American College of Preventive Medicine, Inc., Hotel Fontainebleau, Miami Beach, Fla.

October 20-26—Annual Otolaryngologic Assembly, postgraduate course, University of Illinois College of Medicine, Chicago.

October 22-23—American Cancer Society, Biltmore Hotel, New York City.

October 22-26—American College of Chest Physicians postgraduate course, Clinical Cardiopulmonary Physiology, Knickerbocker Hotel, Chicago.

October 26-30—American Heart Association, Inc., Sheraton-Cleveland Hotel, Cleveland.

October 27 - November 1—American Academy of Pediatrics, Palmer House, Chicago, Illinois.

October 28-31—American College of Gastroenterology, The Morrison, Chicago, Illinois.

October 29-31—American Association for the Surgery of Trauma, The Homestead, Hot Springs, Virginia.



OPEN AND CLOSED HEART MASSAGE

John L. Moore, Jr., *Atlanta*

TWO RECENT DECISIONS bearing on the duty of a surgeon to perform a thoracotomy upon a patient in cardiac arrest raise some interesting questions.

In the first case a patient was undergoing surgery at the Key West Navy Hospital in the nature of an exploratory laparotomy. At the first incision the patient did not bleed. While the attending physician injected ephedrine intravenously and into the patient's heart chamber and heart musculature, more than four minutes elapsed before an emergency thoracotomy was performed on the patient.

The trial judge in the United States District Court for the Southern District of Florida, sitting without a jury, found as a fact that the result of the delay in manual heart massage deprived the brain of necessary oxygen. The result was that the patient suffered a long period of hospitalization and while she survived, she apparently is permanently a paraplegic. The trial judge further found as a fact that the period materially in excess of four minutes between discovery of cardiac arrest and performance of the thoracotomy "constituted a departure from acceptable medical practice at Key West Navy Hospital on January 21, 1958."

Consequently, the United States Government, being responsible for the surgeons and the hospital, was held liable for substantial damages.

In a case arising in Massachusetts, also decided in 1961, a woman undergoing an operation under spinal anesthesia suffered a cardiac arrest. The attending physician used artificial respiration and then an emergency thoracotomy. Apparently the patient had suffered brain damage to a rather severe degree before death. The theory of the malpractice action against the attending physician was that they had failed to use the most efficient method of administering oxygen. Expert defense evidence was introduced to the effect that the administration of oxygen could have done no good until heart action was restored by the thoracotomy. Directed verdicts for the doctors

were affirmed by the Supreme Judicial Court of Massachusetts.

In the latter case, it is interesting to see that neither the plaintiff's attorneys nor the courts seem to consider the issue of whether the delay in performing the thoracotomy might have caused the brain damage. It appears that a holding could well have ensued similar to that of the Florida case to the effect that waiting more than four minutes is per se negligence.

Although both the Florida and Massachusetts cases were decided in 1961, their facts related to occurrences more than three years before. Of course, the development of closed chest heart massage occurred after the facts considered in the cases.

If before the development of the closed chest heart massage technique medical practice in the Key West Navy Hospital required the performance of a thoracotomy in a short enough period after the patient suffered cardiac arrest to prevent brain damage, it is likely that medical practice now would call for immediate employment of the method of closed chest heart massage. Of course, in cases where that technique cannot be used or where it is unsuccessful in reviving the patient, presumably a thoracotomy is still legally indicated if the reasoning of the Florida decision is followed. In any event, the implication of the Florida decision is that a surgeon may be held to be negligent if he fails to perform a thoracotomy within four minutes or such lesser period as is necessary to prevent brain damage. Presumably, also the surgeon before beginning an operation should know the condition of his patient so that he need not encounter any great delay in attempting unsuccessful closed chest heart massage.¹

References

1. The cases commented upon are *Kolesar v. United States*, 198 F. Supp. 517 (S.D. Fla. 1961), and *Erban v. Kay*, 174 N.E. 2d 67 (Sup. Jud. Ct. Mass. 1961).

Prepared at the request of the Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller and Gaines, general counsel for the M.A.G.



PROBLEM OF MENTAL RETARDATION IN GEORGIA

Norman B. Pursley, M.D., *Gracewood*

THE STATE OF GEORGIA, with an approximate population of four million people, is estimated to have 120,000 mentally retarded individuals. This number represents three per cent of the general population, a figure which is commonly accepted for the incidence of mental retardation. The Georgia Association for Retarded Children¹ reports that out of every 100,000 children born, 700 have heart disease, 45 are blind, 1050 are cerebral palsied, but 3000 are mentally retarded.

The degree of retardation varies within the group. The largest number of this special population, or 75 per cent, is only mildly retarded. These are the Educable who may be absorbed into the community, becoming to a large part independent socially and economically. About 20 per cent of this mentally retarded group, the Trainable, will need close supervision and support, but they may develop simple skills and self care. The remainder, the non-trainable or extremely retarded, constitutes about five per cent of the retarded population. These retardates are almost completely dependent upon the care of others.

Complexity of Problem

The problem of mental retardation is complex partly because it is not a single disease but the resultant conditions from scores of causes. It is complex because it involves not only most of the medical disciplines but nursing, education, psychology, public health, sociology, and economics as well.

Mental retardation more often presents an individual with multiple handicaps rather than a single problem. Dr. Samuel Wishik's study² of handicapped children in two representative Georgia counties with regard to urban-rural distribution and racial pattern found that ten per cent of all children under 21 years of age had one or more of twelve handicapping conditions. A third of the handicapped children had only one handicap; another third had two; the other third had more than two with some children having

as many as six handicaps. Dr. Wishik estimated that four per cent of the children under 21 years of age were mentally retarded. The mental retardate is often found to have other handicaps: personality disturbance or problems in cosmetics, speech, eye and vision, hearing, orthopedics, orthodontics, heart disorders, cerebral palsy, and epilepsy.

Rehabilitation

Almost every retarded person can be helped to some degree. Failure to seek improvement results in regression with all groups. This is an accepted truism when referred to normal situations but is not customarily applied in reference to mental retardates. To reach full potential a normal individual needs proper environment, care, love, and stimulation. So, too, has the retarded individual these basic needs. While the potential for the retarded will not result in the same achievements which the normal or superior person would expect to reach, the dynamic operative forces are the same.

Both professional and lay people have been giving increasing attention to the needs of the retarded of all ages. Offering help to the retarded from the Health Department are such divisions as the Crippled Children Service, Child and Maternal Health, Community Mental Health Service, Public Health Nurses, Milledgeville State Hospital, and Gracewood State School and Hospital. In the Department of Education the divisions of Instruction, Vocational Education, and Vocational Rehabilitation all offer direct resources to the mental retardate, his family, and community. The Welfare Department offers aid through the Division of Child Welfare, the Training Schools, and the foster home system.

Other resources include religious, civic, private, and professional groups. The Georgia Association for Retarded Children, United Cerebral Palsy, the National Foundation, Georgia Society for Crippled Children and Adults, and the Georgia Association

for the Blind offer in varying degrees additional aid toward solving problems surrounding mental retardation.

Medical students are being given a more thorough orientation into the problem of mental retardation. All senior students from the Medical College of Georgia since 1955 have spent several days at nearby Gracewood. First-year pediatric residents spend two months as a member of the Gracewood medical staff. Consultative services and research in mental retardation have been mutual projects of the Gracewood and Medical College staffs. Both of the medical colleges in Georgia have expanded their diagnostic services for the retarded individual.

Two state institutions, Gracewood State School and Hospital and Milledgeville State Hospital, share the major burden for providing institutional care for mental retardates. Gracewood, the only state

institution devoted exclusively to the care of the mentally retarded, is today 20 per cent overcrowded. With an enrollment of around 1600 and a waiting list of over 900, this institution is presently unable to provide adequate services to the total state population of mentally retarded persons and their families. Completion of the facilities now under construction at Gracewood for severely physically afflicted mental retardates and other proposed construction will help to alleviate the situation somewhat.

REFERENCES

1. Information from a folder issued by the Georgia Association for Retarded Children, Inc., 210 Walton Building, 87 Walton St., N.W., Atlanta, Georgia.
2. "Handicapped Children in Georgia; a Study of Prevalence, Disability, Need, and Resources," Samuel M. Wishik, MD, MPH SAPHA: *American Journal of Public Health*, Vol. 46, II.

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia

BLOOD BANK STANDARDS REVISED

The basic document for voluntary accreditation of blood banks has been revised and is available for distribution, the Joint Blood Council announced today. "Standards for a Blood Transfusion Service," third edition, 1962, provides improved guidelines for evaluating and conducting an acceptable blood transfusion service in hospitals and community blood banks.

Dr. Gunnar Gundersen, President of the Council and a past president of the American Medical Association said: "The use of the previous editions of these Standards has been gratifying and undoubtedly has played an important part in elevating and maintaining high quality blood services for our patients. The new Standards show the results of constant study in this area for the past two years." Close liaison between the Standards Committee of the American Association of Blood Banks and the Council's Scientific Committee in jointly preparing the document since last revised has brought advanced technical knowledge to blood handling institutions.

The section on donor requirements is now a part of the text where it was in the appendix of the earlier editions. Other important changes include improved procedures for compatibility, or crossmatch, testing. Sterility testing has been defined. The section describ-

ing Packed Red Cells has been written into clearer language. The section on the use of blood in emergency situations has been expanded and revised. A new and improved form for investigating transfusion reactions has been added.

The earlier Standards have received the approval or endorsement of the American College of Surgeons, the Joint Commission on Accreditation of Hospitals, the Defense Ministry of West Germany and is used in the accreditation program of the American Association of Blood Banks and as guiding principles by the American Red Cross blood program. Federal medical agencies such as the Navy and Army use the document as reference standards in training programs.

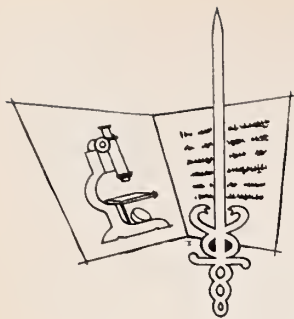
Copies may be obtained directly from the Joint Blood Council, 1500 Massachusetts Avenue, N.W., Washington 5, D. C., at \$1.00 each, payable with the order. A discount of 25 per cent may be given on orders of 12 or more.

Member Institutions of the Joint Blood Council are the American Association of Blood Banks, American Hospital Association, American Medical Association, American National Red Cross, and American Society of Clinical Pathologists. The Council also publishes a "Directory of Blood Transfusion Facilities and Services."

UNKNOWN PRESCRIPTIONS

The thrust of invention and development has placed us all in an informational pressure cooker, and nowhere is this fact more clinically apparent than in the field of medicine. I am told by a doctor friend that seven out of ten prescriptions written today are for

items unknown to medicine before World War II. The communications problems that result are more serious here than in any other area, since human health and life itself are involved.—David Sarnoff, RCA Board Chairman, to National Health Council.



CANCER REGISTRIES IN GEORGIA

Robert L. Brown, M.D., *Atlanta*

IN AN EFFORT TO IMPROVE the quality of care and the effectiveness of treatment of patients who have cancer, the American College of Surgeons for many years has inspected cancer programs throughout the country and has approved those which come up to standard. The list of approved programs is published by the American College of Surgeons and may be obtained from that organization. The state aid cancer program in Georgia supported by the Division of Cancer Control of the Georgia State Health Department requires this approval before a hospital can participate in the state aid program. There are at present 19 approved cancer clinics in the state of Georgia.

Scope of Registries

Since 1956 hospitals seeking this approval have been required to maintain a cancer registry. This is a repository of records containing pertinent information on diagnosis, treatment, follow up and end results of all patients private and non-private with a diagnosis of cancer who have been admitted as in-patients or seen as out-patients at the hospital or its tumor clinic. Included in the registry are (1) An accession book listing all new cancer patients; (2) A file by site of disease which is made up of abstracts of the clinical records of all cancer patients; (3) An alphabetical index by name of patient; (4) A follow up control system by which follow up information can be entered periodically on the abstract card; (5) A method for statistical study (in Georgia this is done by preparing a code sheet on each patient from which IBM cards are punched in the statistical section of the State Department of Health). In this way it is possible for physicians to know the results of cancer treatment in their hospital or community. Efforts to improve treatment can be made when indicated so that the results will approximate those attainable throughout the country. The

approved tumor clinics have been aided in this endeavor by the Georgia Division of the American Cancer Society which supplies the necessary abstract cards and other forms used in the registries and which also contributes to the support of the registries by payments based upon the number of new cases recorded each month. Another contribution of the Georgia Division of the American Cancer Society to this program has been the support of a coordinator to assist the tumor registry secretaries throughout the state in setting up their registries and in keeping accurate records. The Division of Cancer Control of the Georgia State Department of Health cooperates in the registry program by making available staff and equipment for statistical studies of the case material in each clinic and also of the combined cancer cases reported.

Five Year Results

Through December 1960, 37,786 cases of cancer were recorded on punch cards and were available for statistical analysis. Since the program was not begun until 1956 the data for five-year end result studies is not yet adequate but within a few years enough patients will have been followed five years or more to make it possible to evaluate the end results of treatment of cancer in the participating hospitals. Certain salient facts, however, are already available. These relate to the age of the patients who develop cancer, the stage of disease present when the cancer was diagnosed and the relative incidence of various types of cancer in Georgia as reflected by these studies. It is recognized of course that all cases of cancer in the state are not reported but nevertheless the number reported is large enough so that the statistics have meaning.

In this group of 37,786 cancer cases cancer of the skin, as might be expected, showed the greatest incidence among both men and women. When

cancer of the skin was excluded the most frequent site of cancer in the total group was the uterus with breast second and colon and rectum third. Among women cancer of the uterus was first, cancer of the breast second and cancer of the colon and rectum third. Among men on the other hand cancer of the lung was first, prostate second, and colon and rectum third. Cancer of the stomach which used to be one of the most frequent is now sixth on the list for men and seventh for women.

In so far as age is concerned it was of considerable interest to discover that only 32 per cent of the cancer occurred in individuals over 65 whereas 62 per cent developed in men and women from 31 to 65, during the most active and productive years of their lives. Six per cent of the total or 2365 cases occurred in individuals under 31 years of age.

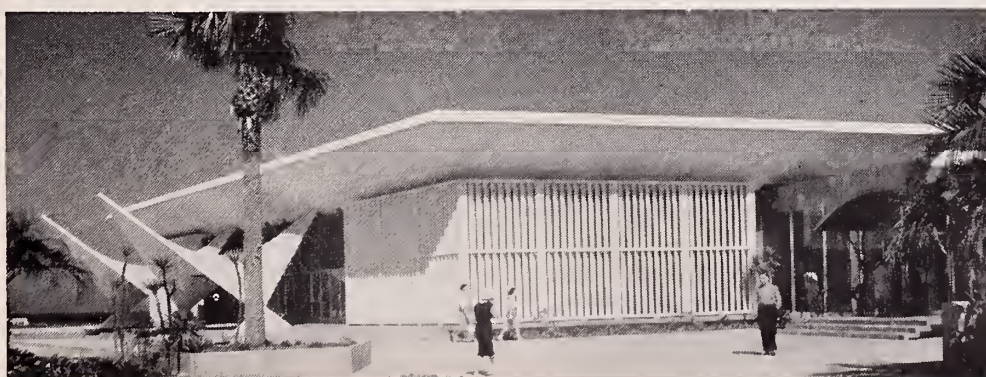
Many patients in Georgia still have advanced cancer before a diagnosis is established. Usually this

is due to the fact that either the patient did not recognize the danger signals of cancer or that he or she ignored them. In some instances the responsibility for delay in diagnosis must be shared by physicians and it is apparent that a need still exists for greater education of the general public and also for further education of physicians in regard to the early symptoms and physical findings caused by cancer. After excluding skin cancer 55 per cent of the total number of patients so far recorded in the cancer registry showed evidence of extension of their disease beyond the primary site when they were first seen in the tumor clinics. In 36 per cent this extension was still regional and amenable to treatment but in 19 per cent progression of the disease to distant sites had already occurred.

The cancer registry program should be of increasing value as the years go by and information will be published periodically regarding the results of statistical studies on the registry material.

Approved by Professional Education Committee, Georgia Division, ASC.

**Plan now to attend the 109th Annual Session
of the
MEDICAL ASSOCIATION OF GEORGIA
May 5-8, 1963
Jekyll Island, Georgia**



**Meetings — AQUARAMA
Headquarters — BUCCANEER MOTEL**



HYPERTENSION: CURRENT CONCEPTS OF MANAGEMENT

Louis L. Battey, M.D., *Augusta*

SUSTAINED ELEVATIONS of diastolic blood pressure above 90 mm. Hg. are productive of abnormal alterations of myocardial and arterial structure. Over the years hypertensive cardiovascular disease is the result and becomes a serious source of morbidity and mortality in the 30 to 60 year age group.

It is now generally accepted that the degree of atherosclerosis and left ventricular hypertrophy appear quantitatively related to the severity and the duration of the hypertension. Therefore effective hypotensive treatment is indicated in any patient with abnormal sustained diastolic levels of pressure. Factors such as obesity and emotional tension should be considered in arriving at the true baseline blood pressure. Most authorities agree that the upper limit of normal diastolic range is 90 to 95 mm. Hg in the younger individual. The patient with early labile hypertension should theoretically benefit from drug therapy despite the absence of a constant fixed elevation of diastolic pressure. Statistical analysis of hypotensive treatment in this type patient is lacking.

There is no such thing as "benign hypertension." It is a misleading term and should be discarded. Recent studies have shown that even the slightest sustained abnormal elevation of diastolic pressure is accompanied by a higher mortality rate. The incidence of coronary disease is increased in the presence of the left ventricular hypertrophy of hypertension. Coronary thrombosis is much more common even if the hypertrophy and hypertension are minimal in degree.

So called "essential hypertension" accounts for 80 to 90 per cent of all hypertension. The cause of this syndrome is not known, but recent investigation supports the concept that a defect in angiotensin metabolism may be a prime mechanism. It is felt that this metabolic abnormality is inherited as a Mendelian dominant. In fact the diagnosis of essential hypertension is doubtful in the presence of a negative family history for this condition.

Unilateral renal disease is a much more common cause of hypertension than was formerly suspected. It is the responsible mechanism in approximately

five to ten per cent of all hypertension. Renal arteriograms are much less dangerous than early studies would indicate and should be used more frequently in the initial hypertensive work-up. If done with the proper technique, complications from aortography are extremely rare.

Arteriosclerotic hypertension seen in elderly individuals with rigid inelastic arteries will rarely cause diastolic pressures above 105 mm. Hg, although the systolic may range well above 200 mm. Hg. These patients do not require hypotensive drug therapy. In fact it is dangerous to use any but the mildest of agents in their management.

Malignant hypertension is always rapidly fatal unless the blood pressure is effectively lowered before too much renal damage occurs. Early recognition of the malignant syndrome is made by a complete funduscopic examination of every hypertensive patient. The occurrence of hemorrhages, exudates, or papilledema is a sign of impending death if therapy is not instituted quickly as soon as the basis for the hypertension has been evaluated. This syndrome constitutes a true medical emergency. If blood pressure is carefully lowered with hypotensive drugs to less damaging levels without producing irreversible uremia, many of these patients can be salvaged. Malignant hypertension in Georgia appears to be much more common in the Negro race and in the male.

Effective drugs for almost every type of hypertensive patient are now available. A goal for therapy with these drugs should be a diastolic pressure as consistently low as can be tolerated comfortably by the patient. The optimal range is the lowest arterial pressure compatible with normal physiologic function. In most cases a diastolic range around 90 mm. Hg is attainable. Postural hypotension is a problem with most of the more powerful agents. This produces a sensation of faintness on standing and is relieved by sitting or lying down. Symptoms are generally more severe in the early morning on rising. It has been suggested that a short period of mild postural hypotension not exceeding ten minutes is not a hazardous symptom in most patients, and in fact is usually a desirable indication of effective hypotensive therapy.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

BOOKS RECEIVED

Cole, Warren H., M.D.; McDonald, Gerald, M.D.; Roberts, Stuart S., M.D. and Southwick, Harry, **DISSEMINATION OF CANCER, PREVENTION AND THERAPY**, Appleton-Century-Crofts, Inc., New York City, 1961, pp. 462.

Redo, S. Frank, M.D., **SURGERY OF THE AMBULATORY CHILD**, Appleton-Century-Crofts, Inc., New York City, 1961, pp. 340.

DeReuck, A. V. S. and O'Connor, Maeve, **CIBA FOUNDATION STUDY GROUP NO. 11, THE MECHANISM OF ACTION OF WATER-SOLUBLE VITAMINS**, Little, Brown and Co., Boston, pp. 118, \$2.50.

Wolstenholme, G. E. W. and Cameron, Margaret P., **CIBA FOUNDATION SYMPOSIUM ON RENAL BIOPSY**, Little, Brown and Co., Boston, pp. 395, \$10.50.

O'Donnell, Walter E., M.D.; Day, Emerson, M.D. and Venet, Louis, M.D., **EARLY DETECTION AND DIAGNOSIS OF CANCER**, C. V. Mosby Co., St. Louis, 1962, pp. 286, \$12.00.

McKusick, Victor A., M.D., **MEDICAL GENETICS 1958-1960**, C. V. Mosby Co., St. Louis, 1961, pp. 534, \$14.50.

Brainerd, Henry, M.D.; Margen, Sheldon, M.D. and Chatton, Milton J., M.D., **CURRENT DIAGNOSIS AND TREATMENT**, Lange Medical Publications, Los Altos, California, 1962, pp. 758, \$8.50.

ED. Roques, F. W., M.D.; Beattie, John and Wrigley, Joseph, **MIDWIFERY**, Williams & Wilkins Co., Baltimore, 1961, pp. 739, \$9.00.

Florey, Sir Howard, **GENERAL PATHOLOGY**, W. B. Saunders Co., Philadelphia, 1962, pp. 1104, \$22.00.

ED. Owen, Joseph Karlton, **MODERN CONCEPTS OF HOSPITAL ADMINISTRATION**, W. B. Saunders Co., Philadelphia, 1962, pp. 823, \$16.00.

Reid, Duncan E., M.D., **A TEXTBOOK OF OBSTETRICS**, W. B. Saunders Co., Philadelphia, 1962, pp. 1087, \$18.00.

ED. Conn, Howard F., M.D., **CURRENT THERAPY—1962**, W. B. Saunders, Philadelphia, 1962, pp. 790, \$12.50.

Lore, John M., Jr., M.D., **AN ATLAS OF HEAD AND NECK SURGERY**, W. B. Saunders Co., Philadelphia, 1962, pp. 490, \$25.00.

Willius, Frederick A., M.D., and Keys, Thomas E., **CLASSICS OF CARDIOLOGY (2 VOL.S)**, Dover Publications, New York City, 1961, pp. 857, \$2.00 per vol.

Cummins, Harold, and Midlo, Charles, M.D., **FINGER PRINTS, PALMS AND SOLES**, Dover Publications, New York City, 1961, pp. 317.

REVIEWS

Gross, Ludwik, M.D., **ONCOGENIC VIRUSES**, Pergamon Press, New York City, 1961, pp. 393, \$12.00.

THE AUTHOR, an exacting and interested student of the subject, has cataloged all of the available scientific evidence concerning neoplasms which have been transmitted from one animal to another by inoculation of filtrates from the tumor.

As interest in the part that viruses play in the etiology of neoplasms has been revived, the number of tumors transmissible by cell-free extracts has likewise

been increasing at an accelerated pace. Although tumors of all animals transmitted by viruses are covered by the author, Dr. Gross's natural interest and, indeed, the vast quantity of productive research in the field insists that the majority of this volume be devoted to tumors in the chicken and mouse.

Dr. Gross writes succinctly, including only the important experimental details and results, and includes excellent bibliographies for the readers' further library research for these details if desired. The volume is concluded with a chapter concerning evidence of viral tumors in human beings and an interesting "working hypothesis" of such etiology.

Neil G. Perkinson, M.D.

Goth, Andres, M.D., **MEDICAL PHARMACOLOGY, PRINCIPLES AND CONCEPTS**, The C. V. Mosby Co., St. Louis, 1961, 551 pp., \$11.00.

THIS IS A COMPACT volume designed primarily as a text for medical students. There is a general emphasis throughout on pharmacologic principles as they apply to specific drugs and to various classes of therapeutic agents.

While the topics are organized in a fairly standard fashion there has been an impressive condensation of subject matter which has been achieved partly by concentrating on important drugs and excluding those which in the author's experience are of relatively minor significance. In addition, most of the material is presented in a highly summarized form with general discussion reduced to a minimum.

This is not (nor is it intended to be) a reference work, and it clearly will be of rather more value to the student as he learns the fundamentals of pharmacology than to the physician concerned with the choice of an appropriate therapeutic agent for a particular patient, or faced with the problem of an unusual toxic or allergic manifestation of drug treatment.

The volume has the advantage of being up-to-date with many of the newer compounds included. Each section is followed by an appropriate list of important references from which the reader may select material for additional study.

James B. Hudson, M.D.

Corday, Eliot, M.D., and Irving, David W., M.D., **DISTURBANCES OF HEART RATE, RHYTHM AND CONDUCTION**, W. B. Saunders Co., Philadelphia, 1961, 357 pp., \$8.50.

THE AUTHORS HAVE presented a monograph on the subject of cardiac arrhythmias based primarily on the study of electrocardiograms; hemodynamic data are also used as well as the bedside approach to such clinical problems. Unfortunately, the subject matter is so large that most topics are over-simplified and discussed superficially. This reviewer found little information not already adequately presented in standard texts of medicine or of electrocardiography.

The drawings (by Mr. Ted Bloodheart, Mr. Bill Miller and Miss Loretta McKinney) constitute the most outstanding part of this monograph. The authors

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the Editor.

PHYSICIANS BOOKSHELF / Continued

have used these drawings to clearly correlate the electrical and mechanical events of the cardiac cycle. Another series of drawings depicts nicely the central nervous system control over heart rate.

Aside from the drawings, there is little to recommend this book for those practicing cardiology or internal medicine. Medical students may find it useful, but it is hardly to be recommended as a reference textbook on arrhythmias.

Charles B. Upshaw, Jr., M.D.

Eastman, Nicholson J., M.D. and Hellman, Louis M., M.D., **OBSTETRICS**, Appleton-Century-Crofts, Inc., New York, 1961, 1230 pp., \$16.00.

THE 12TH EDITION of *Williams Obstetrics* is authored by Nicholson J. Eastman and Louis M. Hellman. The addition of Dr. Hellman, Professor and Chairman, Department of Obstetrics and Gynecology, State University of New York, Downstate Medical Center, adds greatly to the scope of this basic textbook as there is combined the experience of two large teaching services, The Johns Hopkins Hospital and Kings County Hospital.

It is to the credit of the authors that the size of the text has not been increased in spite of the addition of much current material. This has been possible through the elimination of superfluous and outmoded subject matter found in the previous edition.

However, the chapter titles and sequence are identical to the previous edition. The most noteworthy additions have been in the chapter on fetal physiology containing much new information applicable to everyday practice. There is also a completely new section on fetal malformations.

Additions to the subject of placental and fetal physiology have been aided by the recent techniques of measuring the hydrostatic pressures in the intervillous spaces and amniotic sac and the partial pressures of CO₂ and O₂ during labor. The practical application of these facts has led to the revision of many concepts concerning the dynamics of labor and its effect on the fetus. Also new information on placental transfer, fetal homeostasis and asphyxia neonatorum has been included.

Other new subjects include the incompetent cervix and the vacuum extractor, and there is further discussion on the management of the cesarean section scar, antimicrobial treatment of puerperal infection, bacterial shock, x-ray pelvimetry and uterine inertia. Revision may be noted in the chapters on toxemias, anesthesia and endocrines.

Due to its orderly arrangement and sequence of subjects, its readability, and its manageable size, *Williams Obstetrics* continues to be one of the foremost, if not the best, textbook of obstetrics for the student and practitioner. The large bibliographies at the end of each chapter allow exhaustive investigation of each subject.

Charles K. Wright, M.D.

Kroger, William S., M.D., **CHILDBIRTH WITH HYPNOSIS**, Doubleday & Company, Inc., Garden City, N. Y., 1961, 216 pp., \$3.95.

THIS BOOK IS FOR the layman and will be read by many of your obstetrical patients. Regardless of your plans to use or not use hypnosis in your OB practice you will probably find this volume interesting reading. The novice hypnotist will find ample details of Dr. Kroger's technique for induction of hypnoanalgesia. Included in the book is a brief but impressive account of Cesarean section and hysterectomy using only hypnosis for anesthesia. The author's suggestion of group hypnosis (during the prenatal visits) is a practical time saver.

This book may not convince the skeptic that hypnosis is more than a gimmick but it will impress the lay reader. It may never have the widespread impact of Dr. Read's, "Childbirth Without Fear," but when your pregnant patient reads this volume it will have a definite impact on her. Dr. Kroger has encouraged the reader to deliver with hypnosis, disadvantages are never mentioned,—she will be disappointed if you are not a hypnotist.

Tom Leland, M.D.

Tenney, Benjamin, M.D., Little, Brian, M.D. **CLINICAL OBSTETRICS**, W. B. Saunders Co., Philadelphia, 1961, 440 pp., \$8.50.

SEVERAL EXCELLENT standard textbooks have long served the student of Obstetrics. Because of a necessary emphasis on basic physiology, anatomy, and pathology, however, these volumes have not always fulfilled the needs of the clinician. *Clinical Obstetrics* is a relatively compact book, by respected authors with wide experience, covering those problems most likely to be encountered in private practice. Abnormal conditions such as third trimester bleeding, diabetes, and hypertension are well classified, and sound programs of management are offered. Many readers will find the approach to such procedures as sterile vaginal examination and elective induction of labor both reasonable and practical. Statistics, charts, and illustrations, although few, are clear and well chosen. One disadvantage is the scarcity of bibliographic notes, particularly with reference to more recent advances. In summary, this book is highly recommended to anyone interested in the care of the pregnant woman.

Earnest M. Curtis, M.D.

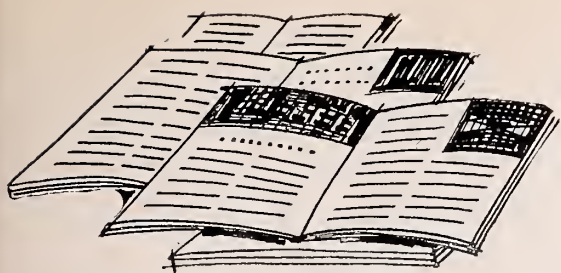
ROCKY MOUNTAIN CANCER CONFERENCE IN JULY

The 16th Annual Rocky Mountain Cancer Conference will be held at Denver's completely air-conditioned Brown Palace West Hotel, July 13-14, and will feature panel discussions on "Neoplasms Complicating Pregnancy" and "Carcinoma of the Colon."

The President of the American Cancer Society and the President-elect of the American Medical Association will participate in the two-day program.

Speakers on the Scientific program will include: Christopher J. Duncan, M.D., of Brookline, Massachusetts; William H. Gordon, M.D., of Lubbock, Texas; George E. Moore, M.D., of Buffalo, New York; and James W. Reagan, M.D., of Cleveland, Ohio.

Further information may be obtained by writing Rocky Mountain Cancer Conference, 1809 East 18th Avenue, Denver 18, Colorado.



The Stethoscope

"IN THE RADIOLOGICAL department of one of the best hospitals in the world a stethoscope hangs on the wall and below it is written:—'Rare and unusually well-preserved fragments known as the *stethoscope* (binaural type), circa 1918 formally in common use in the diagnosis of pulmonary and cardiac disease. This contraption was developed by Laennec early in the 19th century and was actually in general use until the roentgen era.'"

Peart, W. S., and Rob, C.: Arterial Auscultation. LANCET 2:219, 1960.

Subacute Bacterial Endocarditis

THE OCCURRENCE of atrial fibrillation preceding subacute endocarditis is thought to be rare. A possible explanation for this is that once a patient has diseased valves from rheumatic heart disease he becomes liable to it at any time in life, whereas atrial fibrillation is a relatively late development. One hundred sixty-seven patients with subacute bacterial endocarditis were observed at the University of Minnesota Hospital during the 20 year period 1939-1959. The most frequent abnormal physical and laboratory findings were murmur(s) (99.5 per cent), fever (95 per cent), increased erythrocytic sedimentation rate (94 per cent), positive blood culture (83 per cent), cardiomegaly (75 per cent), petechia (70 per cent), and anemia (64 per cent). The mortality rate was 51 per cent.

Tamkey, G. A.: Subacute Bacterial Endocarditis at the University of Minnesota Hospital, 1939-1959, Ann. Int. Med. 55:550-561, 1961.

AT THE LAST MEETING of the Southern Medical Association a very significant and encouraging paper on the treatment of skin cancer was presented by Dr. John M. Knox of the Department of Dermatology and Pathology at Baylor University College of Medicine in Houston, Texas. He recorded a total of 1352 skin cancers which were observed and treated at the Jefferson Davis Hospital Tumor Clinic from January 1, 1939 through September 1, 1960.

In this group of 1352 histopathologically proven malignancies, followed for one year or longer, there were 753 basal cell carcinomas, and 594 squamous

cell carcinomas. For basal cell carcinomas the curettage electrodesiccation method and irradiation proved equally satisfactory — 97 per cent five year cure rate. Excision yielded a good, but not satisfactory result since the cure rate in this group was 84.5 per cent. With the squamous cell carcinomas the curettage and electrodesiccation technique was still superior. However, surgical excision produced a 91.4 per cent cure rate, and was slightly more effective than irradiation alone which produced an 87.9 per cent cure rate. In this series of 594 squamous cell carcinomas there were only seven instances in which post treatment metastases were discovered. Four were among the 90 individuals treated with irradiation, and three followed surgical excision. However, none of the patients in this series had died as a result of cutaneous malignancy.

The Pursuit of the First Rate

Loyal Davis, M.D.

The existence of a cult of mediocrity is evident in many phases of our national economy. One of the more obvious is the system under which all workmen . . . irrespective of their skill, attitude or talent . . . receive the same pay for the job.

The doctor of medicine and, to a great extent, the surgeon must learn to analyze himself and establish his highest level of performance and integrity. The initiative and responsibility for becoming first rate rest with the individual.

Address to Mont Reid Society, Oct. 3, 1961.

Atraumatic Technic

A thorough scrub, careful preparation and draping of the operative site, and vigilance against breaks in technic are most important in avoiding wound infections.

Constant sponging of living tissue is analagous to sandpapering the conjunctiva. A dry sponge is a harsh abrasive and should be used as such.

Crushing forceps and hemostats should never be used on skin flaps, as they leave areas of devitalized skin.

CLINICAL CONCEPTS / Continued

Exposed tissues, as those in a neck or breast operation, should be moistened frequently with saline solution.

Cleveland Clinic Quarterly, 28:157, July 1961. E. R. Dykes, M.D. and Robin Anderson, M.D.

RECONSTRUCTIVE VASCULAR SURGERY

A COMPREHENSIVE REVIEW of the present status of vascular surgery, its pitfalls and successes, has been compiled by a well qualified student of the subject. This is recommended reading for internists, pediatricians, urologists as well as the new crop of vascular surgeons.

Robert H. Shaw, The New England Journal of Medicine. Vol. 266, No. 7: February 15, 1962.

CHANGES IN THE TREATMENT OF CANCER OF THE BREAST

A SUPERB PRESENTATION of some advances that have been made in the treatment of cancer of the breast in recent years together with suggested guidance in the treatment of the individual patient by two surgeons trained in the Halstedian meticulous surgical technique.

I. Ridgeway Trimble and Frances H. Trimble, International Abstracts of Surgery—SG&O. Vol. 114: No. 2, pp. 103, February, 1962.

RETROPERITONEAL TUMORS AND HYPOGLYCEMIA

HYPOGLYCEMIA ASSOCIATED with large fibrogenic extrapancreatic neoplasms has been sited, to our

knowledge, only 25 times in medical literature. The tumors in this group have been of mesothelium origin, and in varying stages of cellular maturity. The mechanism by which such tumors influence carbohydrate metabolism is speculative. Several hypoglycemic symptoms have typified the reported cases. Temporary relief has resulted from oral or parenteral ingestion of carbohydrate. Surgical exploration or necropsy has revealed the presence of large tumors, usually fibrogenic. When surgical removal has been feasible the hypoglycemic symptoms have abated, only to reappear with recurrence of the neoplasm."

J. C. T. Rogers & J. H. Houseworth—Large Fibrogenic tumors and hypoglycemia—J.A.M.A. 178,1132, 1961.

THE CARCINOID SYNDROME

"IT HAS BEEN observed repeatedly that the serotonin-production gut carcinoids usually do not cause clinical manifestations of hyperserotoninemia until appreciable amounts of serotonin are produced by metastasis, usually hepatic. This is thought to be due to the fact that serotonin produced by gut tumors immediately drains via the portal system to the liver, where it rapidly is metabolized by the abundant monoamine oxidase present. Hence, in order to produce the syndrome of hyperserotoninemia, hepatic or rather distant metastasis are required in order to secrete serotonin into the caval system."

R. R. P. Warner, et al.—Serotonin Production by Bronchial Adenomas without the Carcinoid Syndrome—J.A.M.A. 178: 1175, 1961.

AMA TO MEET IN CHICAGO'S NEW McCORMICK PLACE

Physicians attending the 111th Annual Meeting of the American Medical Association June 24-28 in Chicago will view over 700 exhibits and hear scientific papers in the air-conditioned comfort of America's newest and most modern exposition center—McCormick Place.

Doctors who attended the last Annual Meeting held in Chicago—in 1956—have unpleasant memories of extremely hot, humid weather and poor facilities on the old Navy Pier. Those planning to attend the 1962 meeting are looking forward to their first visit to the new \$34,000,000 convention "city" on the lakefront which boasts unobstructed exhibit areas, theaters, attractive restaurants and lounges, shops, and esplanades.

McCormick Place, located on Lake Michigan at 23rd Street, a short distance south of the Loop, is a huge, horizontal structure three blocks long, a block wide and equal to a ten-story building in height. It is fully equipped to handle 30,000 people an hour as they visit

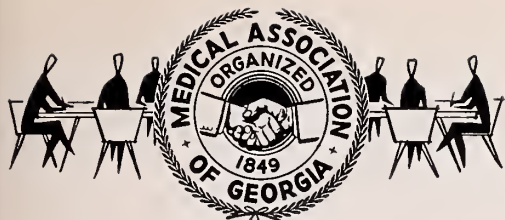
exhibits.

Gross exhibit space is 310,000 square feet in the principal section, roughly the area of six football fields. Exhibitors are welcoming the convenient arrangement whereby a train of railroad cars can run inside the building on a special spur for unloading equipment.

There is ample parking for everyone attending the meeting—exhibitors and others in addition to physicians—in huge lots adjoining the building. McCormick Place is a ten-minute taxi or bus ride from the hotel area in the Loop.

Hotel rooms will be available for everyone. There are 45,700 hotel rooms for guests in the central Chicago area, plus more than 100 hotels in and around the city.

The 1962 meeting will be the first in recent history in which it will be possible to house the entire meeting—scientific sessions, scientific and industrial exhibits, section meetings—under one roof.



THE ASSOCIATION

DEATHS

GEORGE ATTICUS WARD, SR. of Fortsonia community died at the age of 77 on February 25, 1962. Dr. Ward was retired.

He graduated from the Medical College of Georgia in Augusta and practiced in Elbert County from 1913 until his retirement a few years ago. Dr. Ward was a member of the Elbert County Medical Society, the Medical Association of Georgia and the American Medical Association. Also he was a member and a deacon of the Fortsonia Baptist Church.

He is survived by his wife, Corine Dye Ward; three daughters, Mrs. David Hudson and Mrs. Zack Smith of Elbert County and Mrs. Billy Madden of Elberton; a son, George A. Ward, Jr. of Fortsonia; two brothers, William S. Ward and Albert Ward, both of the Rock Branch Community, and six grandchildren.

E. CARSON DEMMOND, Savannah, died on February 28, 1962 at the age of 66 after a long illness. He was well known not only as a physician but also as a civic leader.

Dr. Demmond graduated from Emory University and received his M.D. degree from Johns Hopkins University. He was the former medical director of Telfair Hospital, past president of the Georgia Medical Society, the First District Medical Society and the Savannah Obstetrical-Pediatric Association. He was also past president of the Savannah Health Center and the Hospital Service Association, former member of the board of directors of the Young Men's Christian Association and its general chairman for many years, and was past president of the Georgia Society. Dr. Demmond served as president of the Rotary Club in 1956 and was a communicant of St. John's Episcopal Church.

His survivors include, his wife, Mary Baker Demmond; two sons, E. Carson Demmond, Jr., of Atlanta and William Baker Demmond of Savannah; two daughters, Mrs. Mason G. Robertson of Savannah and Mrs. John C. Parkman of Marianna, Fla.; three sisters, Mrs. William D. Baldwin of Phoenix, Ariz.; Mrs. Eleanor Demmond Bailey of Greeneville, Tenn. and Mrs. Robert Mayhew of Atlanta and ten grandchildren.

GEORGE I. LEBESS, 39, of Rome died March 5, 1962. Dr. Lebess was a member of the medical staff at Battey State Hospital.

He attended medical school at the National University of Havana and did his internship at St. Joseph's Hospital in Yonkers, N. Y. Later Dr. Lebess did his residency and postgraduate work at Lawrence Hospital, Bronxville, N. Y. (Surgery); Essex County Sanatorium, Verona, N. J. (Pulmonary Diseases) and W. T. Edwards Hospital in Tallahassee, Fla. (Pulmonary Diseases).

Dr. Lebess was a member of the Floyd County Medical Society, the Medical Association of Georgia

and the American Medical Association. He was a communicant of St. Mary's Catholic Church in Rome.

His survivors are his wife, Sonia Felipe Lebess; two sons, George and Charles Lebess; one daughter, Miss Linda Lebess, all of Rome; and his mother, Mrs. Diananda Ibarra Lebess.

JAMES RUFUS YOUMANS, 87, of Columbus died after a long illness on March 15, 1962. He was the medical examiner of the Central of Georgia Railroad for 60 years.

He was a member of the First Baptist Church of Columbus and a graduate of Gordon Military Academy and the Medical College in Augusta. Dr. Youmans was a veteran of World War I, having served in the Medical Corps, and was a member of the Muscogee County Medical Society, the Medical Association of Georgia, the American Medical Association, the American Legion and the Elks Club.

Survivors include his wife, Augusta Moore Youmans; one half-sister, Mrs. Olliff Collins, Swainsboro; three nephews, Rufus Youmans, Adrian and C. Brooks Youmans, Macon; and one niece, Mrs. Carl Singletary of Columbus.

AVARY DIMMOCK, SR. of Atlanta died at the age of 68 on March 1, 1962 after an extended illness. He was an associate professor of clinical medicine on the Emory University Medical School faculty.

Dr. Dimmock graduated from the University of Georgia and Emory University School of Medicine. He did his internship and residency at Grady Memorial Hospital in Atlanta. He was a member of the Fulton County Medical Society, the Medical Association of Georgia and the American Medical Association.

CHARLES EDWIN IRWIN, 62, of Warm Springs burned to death on March 29, 1962. He was the former chief of surgeon and medical director of the Warm Springs National Foundation.

Dr. Irwin graduated from Emory University School of Medicine and did his internship and residency at Piedmont Hospital and his residency in orthopedic surgery at the Warm Springs Foundation. He was certified by the American Board of Orthopedic Surgery. He was a member of the American Medical Association, the American Academy of Orthopedic Surgeons, the Fulton County Medical Society, the Medical Association of Georgia, the Southern Medical Association and the Georgia Orthopaedic Association.

SOCIETIES

BIBB COUNTY MEDICAL SOCIETY held their second annual spring meeting with the Athletic Committee in Macon. A program was planned to cover

many of the phases of injuries in athletics. The program was held at the Board of Health Building on April 16.

BLUE RIDGE MEDICAL SOCIETY met at the Watkins Hospital in Eljay on April 10 and heard a paper presented by Dr. William Tryon on hepatitis.

CARROLL-DOUGLAS-HARALSON MEDICAL SOCIETY met during March in Bowdon. H. L. Barker reviewed a number of his interesting medical cases including one involving two separate births in the same patient in less than nine months between deliveries.

COWETA COUNTY MEDICAL SOCIETY met during March in Newnan. The scientific program was a film shown by George Mixon, entitled "Aldosterone and Its Control of Edema."

FULTON COUNTY MEDICAL SOCIETY furnished a panel for answering medical questions put to them by North Fulton High School Delta Club. The group met at the North Fulton Auditorium in Atlanta in March.

GEORGIA MEDICAL SOCIETY met April 10 at their headquarters. The speaker was Dr. William Waring of the Department of Pediatrics at Tulane University who spoke on "New Concepts in Pulmonary Function of Children."

GLYNN COUNTY MEDICAL SOCIETY met during March in Brunswick and B. A. Addison and John Hightower presented a review of the chemo-therapy of cancer.

HABERSHAM COUNTY MEDICAL SOCIETY recently met at Dr. and Mrs. W. T. Ariail's home in Cornelia. Dr. W. D. Hastings of Spartanburg, S. C. was the guest speaker, using the topic, "Initial Care of Trauma."

SOUTH GEORGIA MEDICAL SOCIETY met in Valdosta at the Pineview Hospital recently and had a program on Estate Planning presented by Mr. Hamp Vason, Mr. John Keeble and Mr. David Vaughan.

SOUTHEAST GEORGIA MEDICAL SOCIETY recently met in Vidalia and heard John Fair, Head of the Ophthalmology Department of Medical College of Georgia give a talk on "Toxoplasmosis."

TROUP COUNTY MEDICAL SOCIETY will man the Bloodmobile for the rest of the year in and around LaGrange due to a shortage of interns and residents who usually do this.

WARE COUNTY MEDICAL SOCIETY on March 1 saw a film "Procto-Sigmoidoscopy in Office Practice" at their meeting in Waycross.

PERSONALS

First District

ANTONIO J. WARING, JR., Savannah has relinquished his practice of pediatrics to pursue his hobby, archaeology on a full time basis.

The FIRST DISTRICT MEDICAL SOCIETY recently elected new officers. They include: ROBERT B. GOTTSCHALK of Savannah, president; DAVID ROBINSON of Savannah, vice president; VINCENT CIRINCIONE of Savannah, secretary; and FRANK LOVEL of Statesboro, treasurer.

KATRINE RAWLS HAWKINS, Sylvania attended on March 20-22, a postgraduate course, "Cardiac Emergencies" at the Medical College of Georgia in Augusta.

JAMES MOULTRIE LEE of Savannah was named March 1 as medical director of Emergency Service at Warren A. Candler Hospital.

Second District

The SECOND DISTRICT SOCIETY met April 5 at Radium Springs in Albany. WILLIAM THURMAN of Atlanta, OTIS J. WOODWARD, JR. of Albany and A. A. ZAVALETA of Thomasville presented the program.

CARL S. PITTMAN, SR., Tifton, March 28 spoke to the local Rotary Club on some of the progress made in medicine and surgery during the past 50 years.

Third District

ABE B. CONGER, JR. of Columbus has recently been appointed a special chairman for Mercer University's new loyalty campaign which began throughout Georgia on April 1.

HARVEY L. SIMPSON of Americus recently moved his office from the Clinic Building to 106 E. Church Street.

JOHN VANDUYN, Columbus spoke on March 8 to the meeting of the Fourth District of the National Association of Practical Nurses which was held in LaGrange.

Fourth District

FOURTH DISTRICT MEDICAL SOCIETY met April 4 in Thomaston and heard J. FRANK WALKER of Atlanta speak on "Recent Legislation Affecting the Practice of Medicine in Georgia."

Fifth District

WILLIAM A. HOPKINS, Atlanta on March 28 moderated a seminar sponsored by the Georgia Thoracic Society at Woodruff Auditorium at St. Joseph's Infirmary in Atlanta.

WALTER LYON BLOOM of Atlanta was guest speaker at the March meeting of the Women's Board of the University Hospital in Augusta.

Sixth District

T. NED DAVIS of Irwinton was re-elected on March 1 as county physician of Wilkinson County.

Seventh District

The SEVENTH DISTRICT MEDICAL SOCIETY met April 4 in Rome. Scientific papers were presented

by FREDERICK F. HARDIN of Atlanta and DAVID HENRY POER and JOHN SKANDALAKIS of Atlanta.

E. A. ROPER of Dalton recently attended the International Academy of Proctology meeting in Miami and then flew to Rio de Janeiro, Brazil to attend the AMA-Pan American Medical Seminar.

N. H. HUTCHISON, Trenton was honored on March 30 by the local paper, DADE COUNTY TIMES on the occasion of Doctor's Day.

CARL AVEN of Marietta has recently spoken to the Augusta Area Tuberculosis Association, Inc. and the Flint River Tuberculosis Association on the subject "Don't Stop Half Way."

DAVID WELLS, Dalton was appointed during March by the Dalton Chamber of Commerce as chairman of the Civic and Education Committee.

ROBERT F. NORTON of Rome resigned on March 19 the post of chairman of the Rome City Board of Education. Dr. Norton had been a member of the board since 1951.

Eighth District

JOSEPH M. JACKSON, Folkston attended March 20-22 at the Medical College of Georgia in Augusta, a short postgraduate course, "Pre and Postoperative Care."

GEORGE BARKER and REX STUBBS of St. Mary's and FRANK ROBBINS of Vidalia opened on March 19 a clinic in Woodbine. Office hours will be Monday, Wednesday and Friday, 2:00-5:00 p.m.

LOVICK W. PIERCE, Waycross was recently awarded a 25-year service emblem by the Atlantic Coast Line Railroad.

Ninth District

The NINTH DISTRICT MEDICAL SOCIETY met April 18 in Gainesville. The program was entitled "Symposium on Heart Disease" and papers were presented by BRUCE LOGUE, GORDON BARROW, JOSEPH R. SWARTWOUT, and WILLIAM LOGAN all of Atlanta.

Tenth District

ALBERT R. HOWARD of Augusta became associated with the Anesthesia Associates of Augusta on April 1.

THOMAS W. GOODWIN, Augusta spoke on April 2 to the Augusta Charter Chapter of the American Business Women's Association and the Savannah Rotary Club on the subject of "Certain Aspects of Socialization of Medicine."

WALTER SHEPEARD of Augusta spoke on March 27 to the local Rotary Club on "World Understanding Week."

ROY WITHERINGTON, Augusta on March 25 announced the opening of his office at 1140 Druid Park Avenue for the practice of urology.

SUB-COMMITTEE ON BLOOD BANKS

THE MEETING OF THE "MAG Sub-Committee on Blood Banks" was called to order by Chairman Jack C. Norris at 1:15 P.M., February 26, 1962, in Room 1012 at the Biltmore Hotel, Atlanta, Georgia.

Those present included Chairman Norris, Atlanta; Dr. Walter Sheppard, Augusta, and Dr. Irving Greenberg, Atlanta. Also present at the meeting were Dr. Joseph W. Iseman, Atlanta, representing the American Red Cross, Dr. John Venable, Director, Georgia Department of Public Health and Mr. James M. Moffett, Assistant Executive Secretary, MAG, the liaison officer to the Committee.

Following the luncheon, Chairman Norris made some introductory remarks in which he thanked all those present for attending. He explained that the Committee structure of MAG had been reorganized, and that the Council had expressed a desire for all Boards and Sub-Committees to meet to organize their activities.

Dr. Walter Sheppard discussed the matter of giving transfusions, with particular reference to this procedure in our smaller hospitals. He pointed out that the technology of transfusion had outstripped the availability of M.D.s and properly trained technicians to successfully administer such transfusion without danger to the recipients. He emphasized the danger of "over-use" of blood.

Dr. Sellers Blood Bank Letter

Dr. Norris then read a letter he had received from Dr. Thomas F. Sellers, Director Emeritus of the Georgia Department of Public Health, concerning The Blood Bank Foundation in Atlanta.

Mr. Moffett visited this bank then gave a report of his findings on the occasion when he had made a preliminary investigation in this connection. His report will be considered in detail at the 1962 MAG Annual Session in Savannah.

Dr. Iseman stated that National Institutes of Health regulations (The Blood Bank Foundation operates under NIH licensure) require that M.D. be available when blood is taken from a donor and that donors are to be given certain medical examinations before bleedings.

Dr. Norris then suggested that Dr. Venable install an investigation committee within the State Board of Health for the purpose of investigation, consultation and inspection of Georgia blood banks. General detailed discussion followed this suggestion. Dr. Venable commented that in his view the problem comes under three general headings, to wit: (1) Supply of blood. He pointed out that there is a shortage of blood, and illustrated his point by stating that the State TB Hospital had to go outside to purchase necessary blood; (2) Collection and storage of blood; (3) Administration of blood to include matching and greater safety requirements. He said he is of the opinion that an agency of Government, such as the State Public Health Department, should be concerned mostly with item two, collection, storage and distribution of blood. He stated that he would resist any move to give the state this responsibility unless it were also given authority to do something about such conditions as may be uncovered. He felt further that he would need legal authority, including "right of entry." He also pointed out that standards must also be adopted.

Dr. Venable reported that the State Health Department is presently gathering information from other states on this problem. He added that intensive study must be given before a stand is taken.

Dr. Sheppard expressed himself by saying that the whole matter should be given extensive publicity by MAG as the first step. He also suggested a training school for Blood Bank Technicians at Milledgeville.

On motion (Norris-Venable-Greenberg) the Sub-Committee voted that the Georgia Department of Public Health be requested to consider and undertake necessary studies leading to proposals for possible legislation regarding licensure inspection, etc. of blood banks, at least to the extent of *collection*, *storage*, and *distribution*, and should report to the Sub-Committee on Blood Banks and the Executive Committee of Council in Savannah, with a view toward legislation jointly sought by MAG, the Georgia Department of Public Health, and the Committee.

Red Cross Card System

Dr. Iseman discussed briefly the Red Cross Card System and stated that the Red Cross had made an effort to put responsibility for blood on the family of the recipient, and stated further that the system is working out nicely.

There being no further business, Chairman Norris adjourned the meeting at 3:10 P.M. to reconvene in Savannah during the Annual Session of MAG.

Respectively submitted,
Jack C. Norris, M.D., Chairman

BOARD OF MEDICAL EDUCATION

THE MEETING OF THE MAG Board of Medical Education was held on Sunday, March 11, 1962 at MAG Headquarters Building, Atlanta. Chairman J. W. Chambers called the meeting to order at 2:00 P.M.

Those members present were: J. W. Chambers, LaGrange, Chairman; T. A. Sappington, Thomaston; Ben K. Looper, Canton and George Dillinger, Thomasville. Also present at this meeting was Dr. John T. Mauldin, MAG Secretary and James M. Moffett, MAG staff member.

Dr. Chambers convened the meeting with a few brief remarks concerning the report of the Board to be made to the House of Delegates at the coming Annual Session. He reminded all sub-committee Chairmen that the deadline for receiving this report at MAG is March 15th. He added that he would need each sub-committee report a few days in advance of this date.

Sub-Committee Reports (Clarkesville Laboratory)

Dr. Looper reported that he had only recently visited the Clarkesville Laboratory and that he would file his sub-committee's report direct to Chairman Chambers. He added that he had been very impressed with the new facilities and the competent job being done at Clarkesville.

Sub-Committee on Medical School Course

Dr. Sappington, Chairman of this sub-committee gave a report on the recent meeting of members of his group with certain members of the student body at the Medical College of Georgia and members of the faculty there. He explained that the senior medical students demonstrated much interest in the program. They were given an opportunity to help select the subject matter to be presented and further stated that it had been a most productive meeting. He also said that he felt the best way to expand this program was to make it so popular at the Medical College of Georgia that medical students at other colleges would request a similar program.

Conference on Medical Education

Dr. Dillinger discussed the idea of an MAG sponsored conference on medical education that would attract attendance, not only from Georgia, but from surrounding states as well. He stressed the need for MAG to provide leadership in this field. General discussion followed during which Dr. Mauldin suggested that MAG contact Committees on Medical Education in other State Medical Associations and invite them to attend this conference. Dr. Chambers suggested that the matter be presented to the House of Delegates for their approval. During the discussion it was suggested when the details of this conference are planned that the following people be considered to receive invitations to attend: representatives from both. (Emory and Medical College of Georgia) schools, representatives from the Student AMA, Harmon Caldwell, Board of Regents, Mr. Robert Woodruff, selected members of the faculty from Georgia Medical College and Emory, and Presidents of both medical schools, Dr. Hugh Hussey, AMA, the Board of Health Services at Emory University and others.

On motion (Dillinger-Looper) the Board voted to present this matter to the House of Delegates for approval.

Adjournment

There being no further business to consider the Board adjourned at 4:00 P.M.

MAG BOARD OF INSURANCE AND ECONOMICS MEETING

A MEETING OF THE BOARD of Insurance and Economics of the Medical Association of Georgia was called to order by Chairman David R. Thomas, Jr., Augusta, at 11:00 A.M., March 11, 1962, in the S & S Cafeteria, Macon, Georgia.

Members of the Board of Insurance and Economics present included David R. Thomas, Jr., Chairman, Augusta; H. D. Pinson, Augusta; A. M. Phillips, Macon, and Charles S. Jones, Atlanta.

Also present were Mr. James D. Kenebel, Chicago, representing the National Blue Shield; Mr. H. B. Coolidge and Mr. D. B. Yardley, Jr. of Savannah, representing the Savannah Blue Shield Plan; Mr. John Moye and Mr. John M. Galloway, Columbus, representing the Columbus Blue Shield Plan; Mr. C. J. Anderson and Mr. E. H. Bowman, Atlanta, representing the Atlanta Blue Shield Plan.

Other members of the Association present included William Moore, Atlanta; Paul Scoggins, Commerce; W. F. Homeyer, Macon; Charles D. Hollis, Albany; George Alexander, Forsyth. Mr. M. D. Krueger of Atlanta was present in MAG Staff capacity.

Chairman Thomas reviewed the AMA Board of Trustees action on the proposed National Blue Shield Plan. Mr. Kenebel discussed the background on how the plan was proposed and designed. He also explained the Blue Shield Professional Service Index adoption as a vehicle for such a proposed plan.

Further discussion centered on the coordination of the California Relative Value Schedule and the Professional Service Index. It was brought out that the AMA agreed to ask the State Association to use the Professional Service Index as a basis for this proposed Blue Shield Plan. Discrepancies between the California Relative Schedule and the Professional Service Index in code number, nomenclature and units, were discussed.

During further discussion the question of the necessity for such a proposed plan was raised. Questions were also raised as to "who" the plan was written for, and who will decide the income level for the service benefits. A question was raised as to the possibility of the other purveyors of health care reducing their costs proportionately, and it was noted that no other purveyor of health care was considering such a reduction as was asked of physicians in the proposed Blue Shield National Plan. At this time the meeting was recessed for luncheon.

The meeting was reconvened at 12:35 and Chairman Thomas requested a report from each of the three Georgia Blue Shield Plans as to their feelings on the proposed National Blue Shield Plan.

The Atlanta Blue Shield, as reported by Mr. Anderson, stated that their Board of Directors is waiting on an Association recommendation on the matter and that the Atlanta Blue Shield would cooperate on this plan, if the physicians and the Association want the plan.

The Savannah Blue Shield Plan, as reported by Mr. Coolidge, indicated that they had already approved the plan in principle but wished to see more of the details before final approval.

The Columbus Blue Shield Plan, as reported by Mr. Moye, stated that their Board had accepted the principles of the proposed National Blue Shield Plan, contingent on the Medical Association of Georgia, the National Blue Shield and the American Medical Association.

Discussion then centered on conversion factors for the Professional Service Index in Georgia and there was general discussion of the administrative policy and authority of the local Blue Shield Plans in relation to the National Blue Shield on this matter.

Comparisons for the National Blue Shield Plan with commercial carriers were requested and on motion (Jones-Phillips) it was moved that the Insurance Board study present insurance available, before action on this matter, to determine the need for the proposed National Blue Shield Plan. During the discussion of this motion it was pointed out that the AMA and the National Blue Shield had prepared this program for Senior Citizens with limited incomes; a single person with an annual income from all sources of not more than \$2,500.00, and a married couple with a total income from all sources of not more than \$4,000.00, would be offered this program on a service basis.

A substitute motion (Phillips-Penson) was moved that the Insurance and Economics recommend to the Council of the Medical Association of Georgia, approval, in principle, of the National Blue Shield Plan, as approved by the AMA and the National Blue Shield.

Dr. Jones would not accept the substitute motion. The question was called and Dr. Jones' motion was disapproved. It was recorded that Dr. Jones was on record as in favor of this motion.

The new motion was then made (Phillips-Penson) that the Insurance and Economics Board recommend to the Council of the Medical Association of Georgia, approval, in principle, of the National Blue Shield Plan, as approved by the AMA and the National Blue Shield. After discussion this motion was approved, with Dr. Jones voting against the motion. This motion then stood adopted and approved.

Chairman Thomas then called for the discussion of conversion factors and on motion (Pinson-Phillips) it was moved to recommend to Council the following coefficients; surgery—\$2.78; medicine—\$1.50; X-ray—\$4.00; clinical surgery and pathology—\$4.00 and anesthesiology—\$2.78. After discussion, the question was called, and the vote was for adoption, with Dr. Jones abstaining. This motion was then adopted and approved.

Dr. Moore then emphasized the three following points: (1) that an explanation is due the physicians on why the M.D.s are the only ones who reduced their charges in purveying health care; (2) that the mechanics of arbitration on such a plan be worked out and recorded prior to the commencement of such a plan; (3) that it be clarified and well known as to who the program is designed for.

Further discussion sought additional information for Council for comparison purposes on the matter of what is available from the commercial companies.

It was brought out that this was not the question before this meeting and to compile sufficient comparable information would require much more time than was available before the Council meeting March 17th.

Chairman Thomas than adjourned the meeting at 3:30 P.M.

MEDICAL ASSOCIATION OF GEORGIA COUNCIL MEETING

THE MEETING OF THE COUNCIL of the Medical Association of Georgia was called to order by Chairman George H. Alexander at 2:02 P.M., March 17, 1962, at MAG Headquarters, Atlanta, Georgia.

The invocation was given by Dr. Alexander.

Council members present were: George H. Alexander, Forsyth; Fred H. Simonton, Chickamauga; Thomas W. Goodwin, Augusta; J. G. McDaniel, Atlanta; Linton H. Bishop, Atlanta; Milford B. Hatcher, Macon; John T. Maudin, Atlanta; J. Frank Walker, Atlanta; Joseph B. Mercer, Brunswick; John S. Atwater, Atlanta; Eustace A. Allen, Atlanta; Charles S. Jones, Atlanta; Frank Wilson, Leslie; Walter Brown, Savannah; Paul T. Scoggins, Commerce; Charles Bohler, Brooklet; W. Frank McKemie, Albany; Ralph W. Fowler, Marietta; William Rawlings, Sandersville; M. A. Hubert, Athens; Floyd Sanders, Decatur; Lawrence Matthews, Decatur; C. T. Cowart, LaGrange; H. D. Pinson, Augusta; Henry H. Tift, Macon; W. H. M. Weaver, Macon; C. R. Andrews, Canton; and Virgil Williams, Griffin. Visitors present were: Lester Rumble, Atlanta; John E. Steinhau, Atlanta; W. C. Hathcock, Atlanta; W. W. Moore, Jr., Atlanta; J. H. Hilsman, Atlanta; W. G. Whitaker, Atlanta; S. S. Ambrose, Atlanta; Edgar Woody, Jr., Atlanta; and others. Also present were Mr. Frank Drapalik, MAG Auditor, and Mr. John Moore, MAG Attorney. Staff members present were Mr. Milton D. Krueger, Executive Secretary and Mrs. Catherine Wooten, Executive Assistant.

The minutes of the Council meeting December 9-10, 1961; Executive Committee meetings December 10, 1961, January 4 and 28, and February 18, 1962, were reviewed by Mr. Krueger and, on motion duly made and seconded were approved as read.

It was announced that two members of Council, Addison Simpson, Washington, and George Dillinger, Thomasville were ill. On motion duly made and seconded it was voted to instruct the Secretary to write Dr. Simpson, who is at Mayo Clinic, and Dr. Dillinger in Thomasville.

Certificates of Appreciation

Chairman Alexander appointed the following committee: Thomas W. Goodwin, Chairman, Ralph W. Fowler and John T. Maudin, to bring to reconvened Council meeting Sunday morning the names of the individuals who are to be awarded these Certificates and any others who, in their opinion, should be awarded a Certificate.

The Audit

Dr. McDaniel, Chairman of the Finance Committee, with the assistance of Mr. Drapalik, MAG Auditor, reviewed the 1961 Audit. On motion (Simonton-Brown) it was voted to approve the audit as read.

Treasurer's Report

Dr. Atwater gave the Treasurer's Report. On motion (Bohler-Walker) it was voted to approve the report as given. Dr. Atwater then discussed the suit against a member which was pending for several years, and for which the attorney's statement for services has been submitted. On motion (Atwater-Walker) it was voted that \$300.00 be taken from the Contingent Fund for medical defense.

Physical Therapy Examining Board Advisory Committee Appointments

President Simonton stated that the Georgia Chapter of the American Physical Therapy Association requested two members of MAG appointed to their Advisory Board Committee. On motion (Walker-Fowler) it was voted to authorize the President to make these appointments.

Governor Vandiver Commendation

President Simonton reported that the Georgia Psychiatric Association had written a letter requesting that Governor Vandiver be given a commendation for his work in the field of mental health. On motion duly made and seconded it was voted that President Simonton write the Georgia Psychiatric Association that Governor Vandiver received the Hardman Award in 1960. However, on motion duly made and seconded it was voted that Council refer to the House of Delegates a resolution to Governor and Mrs. Vandiver commending them for their activity in the field of mental health and the program of construction of chapels for mental patients.

Nomination of Dr. McKeown as President-Elect of AMA

President Simonton read a letter from the Oregon State Medical Society asking for support of Dr. McKeown for President-Elect of the AMA. On motion (Simonton-Brown) it was voted to receive this as information and to not instruct the delegates in any way.

Kerr-Mills Program Hospital Letter

President Simonton read a letter regarding an application for a hospital to the Medical Aid to the Aged program. After discussion and on motion duly made and seconded, it was voted to ask the President to write the physician reaffirming the opinion of Council that the standards which have been set up are not unreasonable and Council does not propose to revise them.

Hamilton Letter

Dr. Simonton also read a letter from W. W. Hamilton, M.D., Augusta, regarding a Talmadge Hospital problem. On motion duly made and seconded it was voted to refer this information to the Talmadge Hospital Liaison Committee for investigation and report back to Council.

College of American Pathologists Letter

President Simonton asked if MAG wished to participate in a meeting of the Standards Committee of the College of American Pathologists. On motion duly made and seconded it was voted to refer this matter to the Georgia Association of Pathologists for decision.

Medical Society of New York Award

President Simonton read a letter asking for nominations for the Bernstein Award to be given by the New York Medical Society. On motion duly made and seconded it was voted to refer this to the Sub-Committee on Medical Education.

Tennessee Medical Association Invitation

President Simonton stated that an invitation to MAG to send a representative to the Tennessee Medical Annual Session had been extended. On motion duly made and seconded, it was voted to ask the First or Second Vice President to attend.

Georgia Public Health Association Meeting

President Simonton reported that he had received information about a meeting to be held April 29-May 2, 1962. On motion

duly made and seconded it was voted to refer this to the Sub-Committee on Medical Education.

Southeastern School of Alcohol Studies Meeting

President Simonton read a letter from the Director of the Alcoholic Rehabilitation Service of the Georgia Department of Public Health regarding a meeting to be held August 5-10, 1962. On motion duly made and seconded it was voted to refer this to the Sub-Committee on Medical Education.

Progress of Medical Aid to the Aged Program

Medical Director Mauldin discussed the progress of the MAA program and gave figures on the number of claims approved or rejected. His report was received for information.

Allied Medical Careers Clubs Dues

Secretary Mauldin stated that \$50.00 dues were requested for MAG for membership in the Allied Medical Careers Clubs. On motion duly made and seconded it was voted to take the \$50.00 from the Contingent Fund to pay these dues.

AMA Blue Shield Aged Care Plan

Dr. Pinson gave background information on the AMA Blue Shield Aged Care Plan and reviewed the minutes of the meeting of the Board of Insurance and Economics held March 11, 1962 in Macon which recommended Council approval of the Blue Shield Aged Care plan. Chairman Alexander welcomed the physician guests present to hear the discussion on this subject. Dr. Jones then discussed his viewpoint and following this there was general discussion on the subject. On motion (Walker-McDaniel) it was voted that Council take no action on the AMA Blue Shield Aged Care Plan, but that this be referred to the House of Delegates by means of the majority report of the Board of Insurance and Economics, with a minority report to be filed by Dr. Jones; and that the Board of Insurance and Economics be asked to continue to gather data, and that this data be sent to the delegates prior to the Annual Session.

This portion of the Council meeting was recessed at 5:10 P.M.

The March 18 Council meeting was called to order at 8:20 A.M. by Chairman Alexander.

Medical Discipline Questionnaire

President-Elect Goodwin explained to Council a questionnaire which queried MAG policy on allowing the AMA to take original jurisdiction in medical discipline. There was general discussion on this questionnaire. Dr. Walker discussed the Washington State Medical Disciplinary Board with regard to the Ethical and Legal Conduct of Doctors of Medicine, as a solution to the problem. On motion (Bishop-Mauldin) it was voted that MAG go on record as opposing questions No. 2 and No. 3 and favoring question No. 4. The questions are recorded as follows:

- "2. Does your society feel that the AMA should have original jurisdiction for medical discipline in cases brought to its attention?
.....YesX.....No
3. Does your society feel that the AMA should have original jurisdiction in cases where medical disciplinary bodies at the local and state level have failed to act?
.....YesX.....No
4. Does your society approve the creation of an information clearing house on medical discipline at AMA level?
.....X.....YesNo."

Fourth Annual County Medical Society Officers' Conference

Dr. Bishop reported on the conference held at the Dinkler Hotel, February 17-18, 1962, in Atlanta. Council voted to go on record as commending the Board of Public Service for the fine program and conference.

Annual Session Public Health Officers Section

Mr. Krueger gave a report for Dr. Hydrick, Chairman of the Annual Session Board, who could not be present. Dr. Hydrick made the suggestion that instead of having a special section for Public Health Officers, it might be better for them to combine with Medicine and that a Public Health Officer in the area where the Annual Session is to be held could act as a co-chairman with the chairman of the Georgia Society of Internal Medicine and Georgia Chapter of American College of Physicians, to plan their part of the program. On motion (Simonton-Bishop) it was voted that MAG recommend that the Public Health Officers have a joint section with Pediatrics, Internal Medicine and Psychiatry, and that this recommendation be left to the discretion of the Chairman of the Annual Session Board.

Certificates of Appreciation

The Committee appointed by Chairman Alexander yesterday reported on the names suggested to receive the Certificates of Appreciation: President Fred H. Simonton; First Vice President Linton H. Bishop; Second Vice President Lee H. Battle; Former Treasurer C. Raymond Arp (to be awarded posthumously); Mrs. A. Worth Hobby, President of Woman's Auxiliary to MAG; any Councilor who is not re-elected. With regard to the certificate to the Second Vice President, it was recommended that this not be given this year, as the Second Vice President succeeds to the office of First Vice President, so the certificate could be awarded next year. On motion duly made and seconded it was voted to authorize Executive Committee to award Certificates of Appreciation to the above named individuals and any others deemed worthy. After discussion it was proposed that Henry H. Tift, Macon, and John T. Mauldin, Atlanta, be given Certificates of Appreciation; Dr. Tift for his work on the Annual Sessions for past years, and Dr. Mauldin for his work on Health Care of the Aging. On motion duly made and seconded it was voted to award Certificates of Appreciation to Drs. Tift and Mauldin.

Legislative Report

Dr. Walker reported on: (1) State Legislation—1962 General Assembly actions; (2) Ethical and Legal Conduct of Doctors of Medicine—After discussion regarding the handling of this problem, on motion duly made and seconded, it was voted that the matter of medical disciplinary problems be referred by Council to the House of Delegates with Council's approval as part of the Council report; (3) National Legislation—"WHAM" Conference to be held March 21st at MAG Headquarters; (4) Suggested AMA Legislative Program for State Associations—Resolution, letters, personal visits, advertisements, and Congressional visitation. On motion (Hatcher-Allen) it was voted that Executive Committee send a Resolution to Chairman Wilbur Mills, and all members of the House Ways and Means Committee, to congratulate him on his stand and to give him support. On motion duly made and seconded it was voted to approve the Legislative Report as given.

Lt. Governor Byrd's Letter

Secretary Mauldin read Lt. Governor Byrd's letter thanking the MAG for the letter on MAG policies, as requested by him.

Georgia Hospital-Medical Council Warner Robins Mediation Report

Secretary Mauldin gave a status report on the Houston County Hospital problem. This was received for information.

Headquarters Office Report

Mr. Krueger discussed the following items: (a) Personnel; (b) AMA attendance: On motion duly made and seconded it was voted to pay the expenses of Mrs. Wooten to attend the AMA meeting in Chicago, in June 1962. These expenses are to be paid out of office travel; (c) Office equipment: On motion duly made and seconded it was voted to purchase an electric typewriter for MAG Headquarters office; (d) Permanent part-time personnel policies: On motion duly made and seconded it was voted to approve one week vacation and one week sick leave per year for these employees.

New Business

- (a) Professional Liability Insurance—Information on a possible increase in premium was discussed by Dr. Jones.
- (b) Dr. Brown, Savannah, extended a cordial invitation to

Council to come to the Annual Session in Savannah, and announced a "Dutch Treat" Breakfast, DeSoto Hotel, 7:30 A.M., May 8, which did not appear in the Journal, to kick off the Georgia "AMPAC" program.

(c) Dr. Hatcher gave information on the AMPAC program. On motion (Hatcher-Walker) it was voted that the Secretary draw up a Resolution that the Council of MAG supports "AMPAC," and forward to AMA.

(d) President Simonton urged good attendance at the House of Delegates meeting at the Annual Session.

(e) Hosting AMA Guests at MAG Annual Session: On motion duly made and seconded it was voted that the President should assume responsibility as host.

(f) Dr. Williams discussed certain Civil Defense problems and submitted a Resolution drawn up by Spalding County Medical Society. On motion duly made and seconded it was voted to receive this for information and refer it to the Executive Committee for recommendation.

(g) Milledgeville Chapel: Dr. Mauldin discussed the project of building a chapel at Milledgeville State Hospital. On motion (Jones-Walker) it was voted that Council endorses the campaign for building the Chapel at Milledgeville and gives authority for the President to sign a letter asking for the cooperation of the doctors of Georgia to participate on a local level.

(h) Press Advertising Service: Mr. Krueger discussed press association advertising and asked for a decision of Council for either approval or disapproval. On motion (Walker-Bishop) it was voted that with the permission of legal counsel the two advertisements be published to be paid jointly by the Board of Legislation and by the Board of Public Service.

(i) Dr. Scoggins commended the C. W. Long Medical Society for editorial facts published in the Athens paper, and on motion (Scoggins-Jones) it was voted to recommend that MAG endorse the C. W. Long Medical Society's editorial facts on the Kerr-Mills Bill and ask other county societies to take similar action.

(j) Council expressed appreciation to the Atlanta members of Council and their wives for the hospitality at the social hour and dinner.

(k) Date and site of May Council meeting: May 5, 1962, 7:30 P.M., and May 9, 1962, 12:00 NOON, DeSoto Hotel, Savannah. There being no further business the meeting was adjourned at 11:45 A.M.

EXECUTIVE COMMITTEE OF COUNCIL MEETING

THE EXECUTIVE COMMITTEE of Council meeting was called to order at 11:50 A.M., March 18, 1962, by Chairman Fred H. Simonton.

Members present were: Fred H. Simonton, Chickamauga; George H. Alexander, Forsyth; John T. Mauldin, Atlanta; Thomas W. Goodwin, Augusta; Milford B. Hatcher, Macon; J. G. McDaniel, Atlanta; and John S. Atwater, Atlanta. MAG Staff members present were Mr. Milton D. Krueger and Mrs. Catherine Wooten.

Kerr-Mills Appeal Board Plan

Medical Director Mauldin recommended that the policy changes in the program should remain the jurisdiction of the Executive Committee, and that a board should be set up basically as an Appeal Board, composed of five doctors, to work out the rules and regulations and bring back these recommendations to the Executive Committee for approval. He asked for five names as suggested members of the board, and the following were selected:

Internist: Henry Jennings, Gainesville

Surgeon: Charles M. Wasden, Macon

G.P.: Floyd Sanders, Decatur

Urologist: Major Fowler, Atlanta

Orthopedist: Thomas P. Goodwyn, Atlanta.

The following were selected as alternates: H. Walker Jernigan, Atlanta; E. B. Dunlap, Atlanta; J. G. McDaniel, Atlanta; T. A. Sappington, Thomaston. On motion duly made and seconded it was voted to leave to the discretion of the Medical Director the appointment of alternates if necessary.

Pension Plan for Employees

Tabled until April Executive Committee meeting for a report by Dr. McDaniel.

Florida Medical Association Fraternal Delegates

On motion duly made and seconded it was voted that the President should appoint fraternal delegates to the Florida Medical Association Annual Session and so notify the FMA President.

Advisory Board Appointments for Physical Therapy Association

Chairman Simonton asked for recommendations from the Executive Committee and Wood Lovell, Atlanta; Waldo Floyd, Augusta, and Edsel Dickey, Macon (alternate) were suggested.

New Business

(a) Date and site of April Executive Committee meeting: April 29, 1962, at 10:00 A.M., MAG Headquarters, unless otherwise changed before that date.

There being no further business the meeting was adjourned at 12:25 P.M.

GEORGIA HEART ASSOCIATION MEETING IN SEPTEMBER

Four distinguished physicians will comprise the faculty at the Georgia Heart Association's Fourteenth Annual Meeting and Scientific Sessions to be held at Jekyll Island Friday and Saturday, September 7 and 8, 1962. Each of the speakers will present two papers, one on Friday afternoon and the other Saturday morning.

Speakers and their subjects are as follows:

S. GILBERT BLOUNT, JR., M.D., Professor of Medicine, University of Colorado, Denver, Colorado—"The Heart in Pulmonary Emphysema" and "Tetralogy of Fallot, Results of Surgery in Current Thinking As Regards Surgical Approach."

RICHARD G. LESTER, M.D., Professor and Chairman, Department of Radiology, Medical College of Virginia, Richmond, Virginia—"Selected Angiocardiography in the Diagnosis of Congenital Heart Disease" and "Roentgen Diagnosis of Adult Cardiovascular Diseases"

WILLIAM DOCK, M.D., Professor of Medicine, State University of New York, Brooklyn, New York—"Has Ballistocardiography Any Value In Practice?" and "Local and Systemic Factors in Atherogenesis and Thrombosis."

HENRY J. L. MARRIOTT, M.D., Director, Medical Education and Director, Cardiology Center, Tampa General Hospital, Tampa, Florida—"Pitfalls in Electrocardiographic Interpretation" and "Arrhythmic Dilemmas."

The session on Saturday, September 8 will end with a panel discussion of selected cardiac cases presented by Dr. Blount with participation by the other guest speakers and the audience.

There is no registration fee for members of the Georgia Heart Association. Registration fee for non-members is \$5.00.

CONSULTANTS I CAN'T STAND

BY HILTON S. READ, M.D.—ATLANTIC CITY, N. J.

I HAVE A BONE or two to pick with some consultants. And by "consultants" I mean not only the specialists to whom you send patients you can't diagnose yourself, but also the one who gets patients you're not equipped to treat yourself. In other words, I mean the specialist on all levels—the full range from the solo practitioner to the staff member of a diagnostic clinic.

Within this vast group there are doctors who do much to give our whole profession a public black eye. They manage this by what they often carelessly do to the reputations of the doctors who refer patients to them. They come in four varieties:

1. *The mound of conceit.* You remember the old Quakerism: "All in the world is queer save me and thee, and sometimes I think thee is a little queer." Too many consultants foster a similar illusion about themselves. It's not too hard to imagine the senior cardiologist at any of 50 medical centers implying to his favorite resident: "Nobody in the Western Hemisphere makes a reliable tracing except you and me, and I'm not sure I hadn't better repeat some of yours."

What's wrong with this arrogance is not so much that it hurts the feeling of the referring doctor, who may himself have given the patient a technically perfect tracing to take with him. It's that for no valid reason it doubles the patient's cost.

My own practice is mainly a referring one, and I'm well aware that it's sometimes necessary to repeat a "questionable" test—or to repeat a good one to see what's happened since its completion. But I object to the routine repetition of tests that have already been administered because "that's our policy." If there's a defense for that policy, I've yet to hear it.

2. *The clam.* This man is generally a surgeon. What he clams up about is the treatment he gives your patient. He means no harm; he's just busy.

Take a certain surgeon who happens to be a close friend of mine. He always has his resident call me the night before he operates on any patient I've sent him. "Mrs. Neal is scheduled for surgery at eight o'clock tomorrow morning in case you want to be there, Dr. Read," he says. Of course I don't want to be there. An internist has no place in an operating room. I'd trade 50 such calls for one call—or even a note—from my friend right *after* the operation. Instead, what do I get? About three weeks later, when Mrs. Neal is back home and I've probably seen her several times, a copy of her hospital discharge summary finally finds its way to me.

Is it so hard for this busy surgeon to phone me an hour or two after he's operated? All I want to hear from him is something like "Mrs. Neal is doing fine. I took out 12 stones." Then, when Uncle Fred and Cousin Joan call my office, we'll have something to tell them. The way it works now, *they* usually tell me. And for them to know more about Mrs. Neal's situation than her own doctor does must strike them as odd.

3. *The far-off Olympian.* This is a man whose voice

you seldom hear. Instead you get his receptionist. She always says the same thing: "I'm sorry, it will be impossible for Dr. Jones to see your patient until next month." Your patient could be in acute cardiac crisis, and you'd still get this answer.

I grant that it's hard to see every new patient the day he calls (though in my office we manage to, even if it's only for five minutes). And certainly referring doctors should indicate the degree of urgency of every case they pass on to another man. There are plenty of patients who can wait until next month. What I'm talking about are the consultants who think a month's wait to see them is like owning a Cadillac—a symbol of success. Admittedly, it does impress some patients. But good snob appeal and good medicine don't go together.

4. *The freewheeling tester.* This one is the biggest menace of all. His freewheeling generally starts when he's a resident. As he makes his rounds, he leaves behind him what I call "the \$500 trail." His theory is that tests don't cost anything (except the hospital's time and the patient's money). So why not use them freely on every patient? Diagnosing without a flock of tests takes too much skill—and effort!

By the time the freewheeler gets out into practice—where he very often finds his way to large clinics—his habits are confirmed, and his diagnostic protoplasm is jelled. If you ask him why he ordered such-and-such a test, he'll look at you as if you'd just stepped out of a buggy and will talk earnestly about "modern methods . . . patients feel reassured . . . can't be too careful . . . only costs an extra \$65." In short, he ordered it for no particular reason at all.

I wish all residents had to justify in writing every test they order. Not only would a lot of money be saved, but a lot of young doctors would be taught to use their minds as well as their hospital laboratories. Learning to depend a bit on their own brains would pay off in better and less costly patient-care for all the rest of their years in practice.

So much for my four consultant types, about which I haven't been entirely in earnest anyway. I don't claim to be completely free of their faults myself—though my associate and I do try to keep costs down for our patients and not undermine the doctors who refer them to us. We always write a personal letter, in longhand, to thank the referring man for each patient. Every morning we make chart rounds of our current patients. And we mail out a progress report once a week on each patient who has been referred to us for hospital care.

Why? Not just to further our public relations. We happened to think that progress reports can be extremely useful to the referring doctor when he gets his patient back. Meanwhile he'll have been spared the awkwardness with Uncle Fred and Cousin Joan that my surgeon-friend let *me* in for.

What it really comes down to is courtesy—a little item we consultants could use a lot more of.

Editor's Note: This article reprinted at the request of a MAG member. "If the shoe fits, wear it."

**JOURNAL
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De Soto Hotel, Savannah

May 6-9, 1962

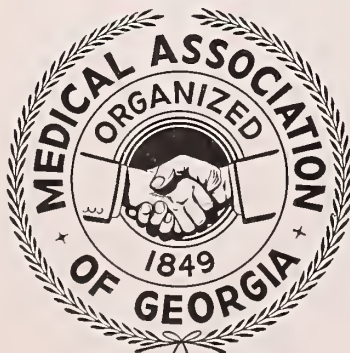
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FIRST SESSION, HOUSE OF DELEGATES

SUNDAY, MAY 6, 1962

THE FIRST SESSION OF THE House of Delegates of the Medical Association of Georgia was called to order by Speaker J. Frank Walker, Atlanta, at 5:05 P.M. on May 6, 1962, in the DeSoto Ballroom, DeSoto Hotel, Savannah, Georgia, in conjunction with the 108th Annual Session of the Medical Association of Georgia.

Speaker Walker called for a preliminary report of delegates' attendance. Harry Brill, Columbus, Chairman of the House of Delegates Credentials Committee, reported that there was a quorum of 40 members present and accounted for, and Speaker Walker declared a quorum present and the House in official session. A complete report made by the Credentials Committee on the attendance at the First Session of the House of Delegates follows:

Attendance

In a compilation of attendance taken from the official roll, 52 county medical societies were represented by their duly elected delegates or alternates. Twenty-two medical societies were not represented at this First Session. Of a total of 144 authorized delegates from their respective medical societies, the official roll showed 101 delegates present at this First Session.

BALDWIN: W. T. Smith; BIBB: Waddell Barnes, Braswell E. Collins, Ferdinand V. Kay, Jule C. Neal; BULLOCH-CANDLER-EVANS: L. H. Griffin; BURKE: J. M. Byne, Jr.; CAMDEN-CHARLTON: G. W. Barker, Jr.; CARROLL-DOUGLASHARALSON: M. L. Johnson, J. I. Vansant; CHEROKEE-PICKENS: C. J. Roper; CLAYTON-FAYETTE: T. J. Busey; COLQUITT: John P. Tucker; COWETA: U. H. Harte; CRAWFORD W. LONG: Goodloe Erwin, Philip W. Warga; DEKALB: Frank E. Morgan, M. Virginia Tuggle; DOUGHERTY: James E. Cantrell, W. P. Rhyne; EMANUEL: R. J. Moye; FLINT: J. T. Christmas; FLOYD: C. E. Gordon, James H. Jenkins, John D. Tate; FULTON: T. J. Anderson, Jr., LeRoy C. Antrobus, Tully T. Blalock, Milton F. Bryant, William C. Coles, W. L. Curtis, M. Bedford Davis, Jr., Edwin C. Evans, Darius Flinchum, John T. Godwin, J. H. Harrison, J. H. Hilsman, J. G. McDaniel, A. Park McGinty, William W. Moore, Jr., William J. Pendergrast, Harrison Rogers, Ted L. Staton, J. W. Veatch, Jr., Robert E. Wells; GEORGIA: John L. Elliott, William H. Fulmer, Lawrence Lee, Jr., Leonard J. Rabhan, H. M. Smith; GLYNN: C. S.

Britt, C. A. Wilson, Jr.; HABERSHAM: Bruce Swain; HALL: Rafe Banks, Jr., Henry S. Jennings, Jr.; JACKSON-BARROW: Paul T. Scoggins; JASPER: E. M. Lancaster; JEFFERSON: C. Roy Williams; JENKINS: John R. Harrison; LAMAR: John B. Crawford; LAURENS: William A. Dodd; MCDUFFIE: A. G. LeRoy; MUSCOGEE: Harry H. Brill, W. B. Dashiell, A. J. Kravtin, W. E. Mayher; NEWTON-ROCKDALE: J. R. Sams; OCONEE VALLEY: George F. Green; OCMULGEE: Reid Gullatt; PEACH BELT: H. E. Weems; RABUN: C. Peter Lampros; RANDOLPH-TERRELL: Carl E. Sills; RICHMOND: Frank P. Anderson, John B. Bowen, C. A. Burgamy, Nick Harrison, R. C. McGahee, Louis O. J. Manganiello, Walter L. Sheppard, Jack Waters; SOUTH GEORGIA: Van B. Bennett, Robert L. Stump, Jr.; SOUTHEAST GEORGIA: Robert W. Oliver, Jr.; SOUTHWEST GEORGIA: Homer L. Lassiter; SPALDING: J. W. Kelley, Virgil B. Williams; SUMTER: C. P. Savage; THOMAS-BROOKS: George B. Dillinger; TIFT: Robley D. Smith; TROUP: J. M. Grisamore, H. Hilt Hammett, Jr.; UPSON: T. A. Sappington; WALKER-CATOOSADADE: John P. Hoover, George C. Vassey; WARE: W. L. Pomeroy, Leo Smith; WASHINGTON: J. E. Lever; WAYNE: E. L. Harrell; WHITFIELD: David A. Wells; WILKES: M. C. Adair; WORTH: H. G. Davis, Jr.

County Medical Societies not represented at this session of the House of Delegates were as follows: ALTAMAHA, BARTOW, BEN HILL-IRWIN, BLUE RIDGE, CHATTAHOOCHEE, CHATTOOGA, COBB, COFFEE, DECATUR-SEMINOLE, FRANKLIN-HART-ELBERT, GORDON, GRADY, MERIWETHER-HARRIS, MITCHELL, POLK, SCREVEN, STEPHENS, TAYLOR, TELFAIR, TRI-COUNTY, WALTON and WARREN.

Reference Committees

Speaker Walker appointed the following House of Delegates Reference Committees:

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REFERENCE COMMITTEE NO. 2: A. J. Waters, Augusta, Chairman; John D. Tate, Rome,

Vice Chairman; I. D. Hellenga, Toccoa, Secretary; W. Earl Lewis, Macon; W. E. Barfield, Augusta; Bruce Swain, Jr., Clarkesville; J. W. Kelly, Griffin; David A. Wells, Dalton; and L. H. Griffin, Claxton.

REFERENCE COMMITTEE NO. 3: Reid Gullatt, Cochran, Chairman; T. A. Sappington, Thomas-ton, Vice Chairman; J. H. Hilsman, Atlanta, Secretary; M. L. Johnson, Jr., Bowdon; C. P. Lampros, Clayton; C. R. Williams, Wadley; L. O. J. Manganiello, Augusta; and F. V. Kay, Macon.

REFERENCE COMMITTEE NO. 4: Braswell Collins, Macon, Chairman; T. Q. Spitzer, Cham-blee, Secretary; W. C. Coles, Atlanta; Lawrence Lee, Savannah; J. E. Cantrell, Albany; Leo Smith, Waycross; and George F. Green, Sparta.

REFERENCE COMMITTEE NO. 5: H. G. Davis, Sylvester, Chairman; C. S. Britt, Brunswick, Vice Chairman; William Moore, Jr., Atlanta, Secretary; Rafe Banks, Gainesville; J. M. Grisamore, LaGrange; W. F. Castellow, Americus; and F. N. Harrison, Augusta.

Credentials and Tellers Committees

Speaker Walker announced the prior appointments of the House of Delegates Credentials Committee and Tellers Committee as follows:

Credentials Committee: Harry Brill, Columbus, Chairman; H. H. Hammett, Jr., LaGrange; and C. J. Roper, Jasper.

Tellers Committee: Jack Waters, Augusta, Chair-man; W. L. Pomeroy, Waycross; and Hugh Hailey, Atlanta.

Approval of 1961 Minutes

To expedite the reading and adoption of the minutes of the 1961 sessions of the House of Delegates held in conjunction with the 107th Annual Session of the Medical Association of Georgia meeting in Atlanta, Georgia on May 7-10, 1961, the Chair entertained a motion that the minutes as published in June, 1961 issue of the *Journal of the Medical Association of Georgia* be approved. On motion duly made and seconded, it was voted that these minutes be so approved as published in their entirety in the June 1961 issue of the *Journal of the Medical Association of Georgia*.

Memorial Service

Speaker Walker led the House of Delegates in the 23rd Psalm in memory of those Medical Association of Georgia Members deceased during the past year. Following this prayer, Speaker Walker read the names of the departed colleagues:

M. P. AGEE, Augusta, May 26, 1961
C. RAYMOND ARP, Atlanta, October 5, 1961
E. A. BARGERON, Waynesboro, August 27, 1961
F. S. BELCHER, Monticello, July 27, 1961

CHARLES H. BLOODWORTH, Atlanta, June 21, 1961

T. L. BYRD, Atlanta, December 19, 1961

ENOCH CALLAWAY, LaGrange, September 26, 1961

RALPH H. CHANEY, Augusta, May 3, 1961

FREDERICK W. COOPER, JR., Atlanta, August 1, 1961

FORREST L. COSBY, Columbus, August 26, 1961

JOHN B. CROSS, Atlanta, July 23, 1961

E. C. DEMMOND, Savannah, February 28, 1962

A. M. DIMMOCK, Atlanta, March 1, 1962

ROBERT W. EILERS, Smyrna, May 4, 1961

CHARLES S. FLOYD, Loganville, January 1, 1962

ELMER L. FRY, Atlanta, October 23, 1961

W. W. GREMMEL, Atlanta, April 1, 1962

H. H. HAMMETT, LaGrange, June 21, 1961

M. G. HENDRIX, Ball Ground, September 26, 1961

PIERRE C. HERAULT, JR., LaGrange, June 14, 1961

C. E. IRWIN, Warm Springs, March 29, 1962

S. A. KOFF, Atlanta, December 18, 1961

GEORGE I. LEGESS, Rome, March 5, 1962

DICK R. LONGINO, Lakeland, Florida, April 26, 1962

E. M. McDONALD, Winder, March 25, 1961

G. W. MOUNTAIN, Augusta, September 18, 1961

J. H. NICHOLSON, Madison, November 12, 1961

HARRY B. NUNALLY, Monroe, November 16, 1961

LEON D. PORCH, Macon, May 25, 1961

B. C. POWELL, Villa Rica, July 25, 1961

EUSTACE H. PRESCOTT, LaGrange, September 8, 1961

M. H. ROBERTS, Atlanta, July 29, 1961

L. C. ROUGHLIN, Atlanta, September 9, 1961

E. O. SCHARNITZKY, Augusta, December 22, 1961

ALVIN E. SIEGEL, Macon, December 10, 1961

MARSHALL R. SIMS, Atlanta, October 9, 1961

S. J. SINKOE, Atlanta, September 14, 1961

G. B. SMITH, Rome, August 7, 1961

H. A. SMITH, Americus, November 7, 1961

W. P. SMITH, Bowdon, October 27, 1961

HILTON F. WALL, Atlanta, April 6, 1962

WILLIAM CHARLES WANSKER, Atlanta, January 6, 1962

HOWELL A. WASDEN, JR., Pavo, October 16, 1961

J. H. WHITESIDE, Statesboro, April 19, 1961

T. I. WILLINGHAM, Atlanta, April 15, 1962

J. R. YOUMANS, Columbus, March 15, 1962

AMA Commendation for John S. Atwater

Speaker Walker, as instructed by MAG Council, read a letter of commendation to John S. Atwater,

Atlanta, from the American Medical Association Council on Medical Services. This recognition was given Dr. Atwater for his work in the field of Health Care of the Aged. Speaker Walker congratulated Dr. Atwater in behalf of the members of the House.

Annual Reports

Speaker Walker called for the Annual Reports of Officers, Council, Councilors, Association Committees, Boards and Sub-Committees as the next item of business.

(A cross reference of the reports of the Officers, Council, Councilors, Association Committees, Boards and Board Sub-Committees and Allied Reports as introduced at this session is listed below with the Reference Committee to which they were referred. The full report, the action by the Reference Committees, and the House of Delegates action is listed under the proceedings of the Second Session of the House of Delegates. See pages 266 to 309.)

REPORTS OF OFFICERS

President—Fred H. Simonton, Chickamauga—Reference Committee No. 1—See Page 267.

President-Elect—Thomas W. Goodwin, Augusta—Reference Committee No. 1—See Page 268.

Immediate Past President—Milford B. Hatcher, Macon—Reference Committee No. 1—See Page 269.

First Vice President—Linton H. Bishop, Atlanta—Reference Committee No. 1—See Page 269.

Secretary—John T. Mauldin, Atlanta—Reference Committee No. 2—See Page 274.

Treasurer—John S. Atwater, Atlanta—Reference Committee No. 2—See Page 277.

Speaker of the House—J. Frank Walker, Atlanta—Reference Committee No. 2—See Page 278.

Vice Speaker of the House—Joseph B. Mercer, Brunswick—Reference Committee No. 2—See Page 278.

AMA Delegates—Henry H. Tift, Macon; Eustace A. Allen, Atlanta; J. W. Chambers, LaGrange—Reference Committee No. 3—See Page 283.

REPORT OF COUNCIL

Report of Council—George H. Alexander, Forsyth, Chairman—Reference Committee No. 3—See Page 284.

REPORT OF COUNCILORS AND VICE COUNCILORS

First District Councilor—Charles Bohler, Brooklet—Reference Committee No. 4—See Page 297.

Second District Councilor—George Dillinger, Thomasville—Reference Committee No. 4—See Page 297.

Third District Councilor—Frank A. Wilson, Leslie—Reference Committee No. 4—See Page 297.

Fourth District Councilor—Virgil B. Williams, Griffin—Reference Committee No. 5—See Page 304.

Fourth District Vice Councilor—Charles T. Cowart, LaGrange—Reference Committee No. 5—See Page 304.

Fifth District Councilor—Floyd R. Sanders, Jr., Decatur—Reference Committee No. 5—See Page 304.

Sixth District Councilor—William Rawlings, Sandersville—Reference Committee No. 5—See Page 305.

Seventh District Councilor—Ralph Fowler, Marietta

—Reference Committee No. 1—See Page 270.

Eighth District Councilor—F. G. Eldridge, Valdosta—Reference Committee No. 1—See Page 270.

Eighth District Vice Councilor—James M. Hicks, Brunswick—Reference Committee No. 1—See Page 270.

Ninth District Councilor—Charles R. Andrews, Canton—Reference Committee No. 1—See Page 271.

Ninth District Vice Councilor—Paul T. Scoggins, Commerce—Reference Committee No. 1—See Page 271.

Tenth District Vice Councilor—M. A. Hubert, Athens—Reference Committee No. 1—See Page 271.

Georgia Medical Society Councilor—Walter E. Brown, Savannah—Reference Committee No. 4—See Page 298.

Muscogee County Medical Society Councilor—W. P. Jordan, Columbus—Reference Committee No. 4—See Page 298.

Muscogee County Medical Society Vice Councilor—Luther H. Wolff, Columbus—Reference Committee No. 4—See Page 298.

Fulton County Medical Society Councilor—J. G. McDaniel, Atlanta—Reference Committee No. 5—See Page 305.

Bibb County Medical Society Councilor—George H. Alexander, Forsyth—Reference Committee No. 5—See Page 306.

Richmond County Medical Society Councilor—Harry D. Pinson, Augusta—Reference Committee No. 1—See Page 271.

REPORTS OF ASSOCIATION COMMITTEES

Finance—J. G. McDaniel, Atlanta, Chairman—Reference Committee No. 3—See Page 285.

Professional Conduct—William P. Harbin, Rome, Chairman—Reference Committee No. 3—See Page 288.

Woman's Auxiliary Advisory—Luther Wolff, Columbus, Chairman—Reference Committee No. 3—See Page 288.

REPORTS OF BOARDS AND SUB-COMMITTEES

Annual Session Board—Peter Hydrick, College Park, Chairman—Reference Committee No. 2—See Page 278.

Constitution and Bylaws Board—W. G. Elliott, Cuthbert, Chairman—Reference Committee No. 2—See Page 279.

Governmental Medical Services Board—Luther H. Wolff, Columbus, Chairman—Reference Committee No. 2—See Page 279.

Maternal and Infant Welfare Sub-Committee—Eugene L. Griffin, Atlanta, Chairman—Reference Committee No. 2—See Page 280.

Public Health Sub-Committee—R. W. Edenfield, Macon, Chairman—Reference Committee No. 2—See Page 280.

Disaster Medical Care Sub-Committee—Edgar M. Dunstan, Atlanta, Chairman—Reference Committee No. 2—See Page 280.

School Child Health Sub-Committee—John L. Bowen, Sandy Springs, Chairman—Reference Committee No. 2—See Page 281.

Rehabilitation Sub-Committee—Robert L. Bennett, Warm Springs, Chairman—Reference Committee No. 2—See Page 282.

Crippled Children Sub-Committee—E. B. Dunlap, Jr., Atlanta, Chairman—Reference Committee No. 2—See Page 282.

Hospital Activities Board—Ralph N. Johnson, Rome, Chairman—Reference Committee No. 4—See Page 298.

Blood Banks Sub-Committee—Jack C. Norris, Atlanta, Chairman—Reference Committee No. 4—See Page 299.

Hospital Relations Sub-Committee—Rafe Banks, Jr., Gainesville, Chairman—Reference Committee No. 4—See Page 300.

Insurance and Economics Board—David R. Thomas, Jr., Augusta, Chairman—Reference Committee No. 3—See Page 288.

Insurance and Economics Minority Report—Charles S. Jones, Atlanta, Member—Reference Committee No. 3—See Page 289.

Relative Value Study Sub-Committee—Harry D. Pinson, Augusta, Chairman—Reference Committee No. 3—See Page 291.

Interprofessional Relations Board—J. G. McDaniel, Atlanta, Chairman—Reference Committee No. 5—See Page 306.

Legislation Board—J. Frank Walker, Atlanta, Chairman—Reference Committee No. 3—See Page 291.

Medical Education Board—J. W. Chambers, LaGrange, Chairman—Reference Committee No. 5—See Page 306.

AMEF Sub-Committee—W. D. Jarrat, Macon, Chairman—Reference Committee No. 5—See Page 308.

Medical School Course Sub-Committee—T. A. Sapington, Thomaston, Chairman—Reference Committee No. 5—See Page 308.

Medical Education Sub-Committee — Walter L. Bloom, Marietta, Chairman—Reference Committee No. 5—See Page 308.

Clarksville Labs. Sub-Committee—Ben K. Looper, Canton, Chairman—Reference Committee No. 5—See Page 309.

Occupational Health Board—T. A. Peterson, Savannah, Chairman — Reference Committee No. 4 — See Page 300.

Public Service Board — Linton Bishop, Atlanta, Chairman—Reference Committee No. 4—See Page 300.

Weekly Health Column Sub-Committee—August S. Yochem, Atlanta, Chairman—Reference Committee No. 4—See Page 300.

Public Service Sub-Committee—Joseph B. Mercer, Brunswick, Chairman—Reference Committee No. 4—See Page 301.

Special Activities Board—John S. Atwater, Atlanta, Chairman—Reference Committee No. 5—See Page 310.

Health Care of Aging Sub-Committee—John S. Atwater, Atlanta, Chairman—Reference Committee No. 5—See Page 310.

Volunteer Health Agency—Robert C. Pendergrass, Americus, Chairman—Reference Committee No. 1—See Page 272.

Cancer Sub-Committee — Robert C. Pendergrass, Americus, Chairman—Reference Committee No. 1—See Page 272.

Mental Health Sub-Committee—Maurice F. Arnold, Hawkinsville, Chairman—Reference Committee No. 1—See Page 273.

ALLIED REPORTS

Journal of the Medical Association of Georgia—Edgar Woody, Jr., Atlanta, Editor—Reference Committee No. 1—See Page 273.

Woman's Auxiliary to the Medical Association of

Georgia—Mrs. A. Worth Hobby, Atlanta, President—Reference Committee No. 4—See Page 301.

General Practitioner of the Year Award

Speaker Walker presented the nominations received for the "1962 Georgia General Practitioner of the Year Award." The following names were read: W. P. Ezzard, Lawrenceville, and King Milligan, Augusta—as the nominations received from the first General Business Session of the Association. Speaker Walker then requested that a vote by secret ballot be taken by the House of Delegates with the House Tellers Committee collecting and counting the ballots. Tellers Committee Chairman A. J. Waters, announced the following results: King Milligan, Augusta, elected "1962 Georgia General Practitioner of the Year."

Hardman Award

Speaker Walker presented the nomination received for the Hardman Award. Dr. Walker stated that at the MAG First General Business Session, Dr. Rudolph A. Bartholomew had been nominated and that in the absence of any other nominations so received, Speaker Walker then requested the Secretary of the Association to cast the unanimous ballot of the house for Dr. Bartholomew. Speaker Walker then announced that Dr. Rudolph A. Bartholomew, Atlanta, was elected the 1962 recipient of the "Hardman Award."

Unfinished Business

Speaker Walker called for unfinished business and there being none, he then moved on to the next item on the order of business.

Supplementary Reports

Speaker Walker then called for new business and the first order of new business requested were the supplementary reports from any Officers, Council, Councilors, Association Committees, Boards, Boards Sub-Committees or Allied Reports. The following supplementary reports were received and introduced as follows:

Supplementary Report of Council No. A: Governor and Mrs. Vandiver Mental Health Commendation—George Alexander, Forsyth, Council Chairman—Referred to Reference Committee No. 3—See Page 292.

Supplementary Report of Council No. B: Hardman Award Selection Revision—George Alexander, Forsyth, Council Chairman—Referred to Reference Committee No. 3—See Page 293.

Supplementary Report of Council No. C: Disciplinary Board (A State Agency) — George Alexander, Forsyth, Council Chairman—Referred to Reference Committee No. 3—See Page 293.

Supplementary Report on the Committee on Professional Conduct No. D: Osteopathic Facilities (hospitals)—William P. Harbin, Jr., Rome, Chairman—Referred to Reference Committee No. 3—See Page 295.

Supplementary Report of the Immediate Past-President No. E: Internship Requirement for Licensure—Milford B. Hatcher, Macon, Immediate Past-President—Referred to Reference Committee No. 1—See Page 269.

Resolutions

Speaker Walker called for the introduction of Resolutions as the second order of new business and the following Resolutions were so introduced:

Resolution No. 1: Laboratories Be Supervised by Qualified Licensed Physicians—John T. Godwin, Atlanta, Georgia Association of Pathologists—Reference Committee No. 4—See Page 303.

Resolution No. 2: Traffic Safety—Reduce Traffic Death and Injuries—Martin Johnson, Carroll-Douglas-Haralson Society—Referred to Reference Committee No. 4—See Page 303.

Resolution No. 3: Confidential Nature of Certain Health Records—Lester Rumble, Jr., Fulton County Medical Society—Reference Committee No. 3—See Page 295.

Resolution No. 4: Chemical and Biological Warfare Weapons—Virgil Williams, Spalding County Medical Society—Reference Committee No. 2—See Page 282.

Resolution No. 5: Insurance Coverage for Mental Illness—Walter Sheppard, Georgia Psychiatric Association—Reference Committee No. 3—See Page 295.

tion—Reference Committee No. 3—See Page 295.

Resolution No. 6: American College of Surgeons Statements — John Hoover, Walker-Catoosa-Dade Medical Society—Reference Committee No. 4—See Page 303.

Resolution No. 7: Create Study Committee on Georgia Adoption Practices—J. W. Veatch, Jr., Fulton County Medical Society—Reference Committee No. 2—See Page 282.

Resolution No. 8: Fee Schedule for Anesthesiologists—A. J. Waters, Georgia Society of Anesthesiologists—Reference Committee No. 3—See Page 296.

Resolution No. 9: Indemnity Basis Health Care Plans—William Moore, Fulton County Medical Society—Reference Committee No. 3—See Page 290.

Speaker Walker called for other Resolutions and there being none, he then called on President Simon-ton.

President Simon-ton introduced Dr. Hugh Hussey, Chairman of the AMA Board of Trustees, who addressed the MAG House of Delegates on the subject "The Triangle of Medicine—Research, Education and Patient Care."

Following the address by Dr. Hussey, Speaker Walker called the first meeting of the MAG House of Delegates recessed at 6:20 p.m.

SECOND SESSION, HOUSE OF DELEGATES

(Recessed)

WEDNESDAY, MAY 9, 1962

THE SECOND SESSION (Recessed) of the House of Delegates of the Medical Association of Georgia held in conjunction with the 108th Annual Session of the Association was called to order by Speaker J. Frank Walker, Atlanta, at 9:05 A.M., Wednesday, May 9, 1962 in the DeSoto Ballroom, DeSoto Hotel, Savannah, Georgia.

Speaker Walker called on Credentials Committee Chairman Harry Brill for a preliminary report of attendance. Dr. Brill reported that more than 40 members of the House of Delegates were registered as present and Speaker Walker then declared a quorum present and accounted for, and the House of Delegates in session. Dr. Brill later made the following complete report on attendance:

Attendance

In a compilation of attendance taken from the official roll, 38 county medical societies were represented by their duly elected delegates or alternates. Thirty-six county medical societies had no representatives at the Second Session. Of a total of 144

authorized delegates from their respective county medical societies, the official roll showed 86 delegates present at this Second Session.

BIBB: Waddell Barnes, Braswell Collins, Rudolph W. Jones, Jr., Ferdinand V. Kay, E. C. McMillan, Jr., Jule C. Neal, Ralph Newton, Jr.; BULLOCH-CANDLER-EVANS: L. H. Griffin; CARROLL-DOUGLAS-HARALSON: M. L. Johnson, Jr., J. I. Vansant; CHEROKEE-PICKENS: C. J. Roper; COLQUITT: John P. Tucker; COWETA: U. H. Harte; DEKALB: F. E. Morgan, M. Virginia Tuggle; DOUGHERTY: J. E. Cantrell; FLOYD: James H. Jenkins; FULTON: Thomas J. Anderson, Jr., LeRoy C. Antrobus, Tully T. Blalock, Claud P. Cobb, W. L. Curtis, M. Bedford Davis, Jr., Edwin C. Evans, Louis Felder, Darius Flinchum, Vernelle Fox, E. D. Grady, J. H. Harrison, William D. Logan, Jr., J. G. McDaniel, A. Park McGinty, William W. Moore, William Pendergrast, W. Vernon Skiles, Ted L. Staton, Charles E. Todd, J. W. Veatch, Jr., R. E. Wells; GEORGIA: John L. Elliott, W. H. Fulmer, Lawrence Lee, Jr., Leonard J. Rabhan, H. M.

Smith; GLYNN: C. S. Britt, C. A. Wilson, Jr.; HABERSHAM: Bruce Swain; HALL: Rafe Banks, Jr., Henry S. Jennings, Jr.; JACKSON-BARROW: Paul T. Scoggins; JEFFERSON: C. Roy Williams; JENKINS: John R. Harrison; MCDUFFIE: Albert G. LeRoy; MUSCOGEE: Harry H. Brill, W. B. Dashiell, A. J. Kravtin, W. E. Mayher; NEWTON-ROCKDALE: J. R. Sams; OCMULGEE: Reid Gullatt; OCONEE VALLEY: George F. Green; POLK: T. E. Cummings; RICHMOND: Frank P. Anderson, William E. Barfield, John B. Bowen, F. N. Harrison, R. C. McGahee, W. L. Sheppard, A. J. Waters; SOUTH GEORGIA: Robert L. Stump; SOUTHEAST GEORGIA: Robert W. Oliver, Jr.; SOUTHWEST GEORGIA: H. L. Lassiter; SPALDING: J. W. Kelley, Virgil B. Williams; STEPHENS: Irving D. Hellenga; TELFAIR: C. J. Maloy; THOMAS-BROOKS: George R. Dillinger; TROUP: J. M. Grisamore; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: J. P. Hoover, George C. Vassey; WARE: W. L. Pomeroy, Leo Smith; WAYNE: E. L. Harrell; WHITFIELD: W. G. Petty, David A. Wells; WILKES: M. C. Adair.

County medical societies not represented at this Second Session of the House of Delegates are as follows: ALTAMAHA, BALDWIN, BARTOW, BEN HILL-IRWIN, BLUE RIDGE, BURKE, CAMDEN-CHARLTON, CHATTAHOOCHEE, CHATTOOGA, CLAYTON-FAYETTE, COBB, COFFEE, DECATUR-SEMINOLE, EMANUEL, FLINT, FRANKLIN-HART-ELBERT, GORDON, GRADY, JASPER, LAMAR, LAURENS, CRAWFORD W. LONG, MERIWETHER-HARRIS, MITCHELL, PEACH BELT, RABUN, RANDOLPH-TERRELL, SCREVEN, SUMTER, TAYLOR, TIFT, TRI-COUNTY, WALTON, WARREN, WASHINGTON, and WORTH.

Election of Speaker and Vice Speaker

Speaker Walker stated that the next order of business for consideration by the House was the election of a Speaker and Vice Speaker. According to the MAG Constitution and Bylaws, Chapter III, Section 6, the next order of business at the second session of the House, immediately following the roll call is the election of a Speaker and Vice Speaker every third year; their terms of office to begin with the adjournment of the House. Dr. Walker explained that Dr. Mercer and he were elected to fill unexpired terms of office vacated by resignation and that these terms of office have now expired, therefore, nominations for three year term of office for the Speaker of the House and Vice Speaker of the House were in order. Speaker Walker then called for nominations for Speaker of the House.

J. Frank Walker of Atlanta was nominated for Speaker of the House by T. A. Sappington, Thomas-

ton and seconded by William Coles, Atlanta and John Elliott, Savannah. Speaker Walker then called for further nominations and there being none, it was moved and duly seconded that nominations be closed and Speaker Walker instructed the Secretary of the Association to cast the unanimous ballot of the House for the election of J. Frank Walker, Atlanta, for a three year term as Speaker of the House of Delegates.

Speaker Walker then called for nominations for Vice Speaker of the House.

Joseph B. Mercer, Brunswick was nominated by Julian Neal of Macon and seconded by L. J. Rabhan, Savannah and C. S. Britt, Brunswick. Speaker Walker called for other nominations and there being none, he instructed the Secretary to cast a unanimous ballot for the House thereby electing Joseph B. Mercer, Brunswick as Vice Speaker of the MAG House of Delegates for a three year term of office.

Reference Committee Reports

Speaker J. Frank Walker stated the next order of business would be the Reference Committee Reports.

Report of Reference Committee No. 1

Tully T. Blalock, M.D., Chairman

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 1 met in Room 400 of the DeSoto Hotel at 8:00 A.M., May 7, 1962. Members present were: Tully T. Blalock, Atlanta, Chairman; T. E. Cummings, Rockmart, Vice Chairman; H. S. Jennings, Gainesville, Secretary; L. J. Rabhan, Savannah; W. A. Dodd, Wrightsville; E. L. Harrell, Jesup; Frank Morgan, Decatur; Robert L. Stump, Valdosta.

President

FRED H. SIMONTON, M.D., Chickamauga

To take the bridge of a ship when the storm clouds hover and the water is turbulent is comparable to assuming the Presidency of an organization such as the Medical Association of Georgia during times of severe economic and political stress. Notwithstanding the temper of the times during my tenure of office I would like to express to you my sincere appreciation for the privilege of serving as President during the past year. From the vantage point one gets as President it is apparent that the Medical Association of Georgia derives its strength from its total membership and not from any person or group of persons. For this reason it will behoove us all to put our shoulders to the wheel and push with all our strength to accomplish the most from our efforts and to make MAG an even stronger organization.

Your President met with the Physical Restoration Group of the Division of Vocational Rehabilitation at

its training conference for all professional personnel from over the state at the General Oglethorpe Hotel near Savannah, Georgia on August 5, 1961 and spoke on "The Role of the General Practitioner in Rehabilitation."

The immediate needs of our state from a medical standpoint as given to Mr. Reg Murphy of the Atlanta Constitution for use in a series of articles, are as follows: (1) Health Care of the Aging (2) Health, Indigent Care (3) Establishment of Burn Centers at strategic points over the state and (4) Mental Health Care.

In August, 1961, the Directors of the Georgia Department of Public Health invited your President to attend a meeting in Atlanta in regard to the establishment of Comprehensive Diagnostic Centers (for children) in the state. The Medical Association of Georgia was represented at this meeting.

As in many other states, our state faces a severe shortage of trained paramedical personnel such as medical technologists, dental technicians, X-ray technologists, nurses and others, and it has been suggested that we establish a training center at Georgia State College in Atlanta. This matter was brought before our Executive Committee on August 27th.

Many are the changes that have been made at our State Hospital at Milledgeville but one addition worthy of mention has been the sponsorship by the Georgia Association for Mental Health, Inc. of the establishment of a clothing store at the Milledgeville State Hospital to replace the drab clothing worn by so many of the patients.

The month of October saw your President making a tour of Mental Hospitals and observing European methods of care for the aged with a group from the State of Georgia.

The question of discontinuance of State Aid Cancer Program on January 1, 1962 due to insufficient funds was discussed with the State Board of Health and the funds were subsequently depleted on January 15, 1962. I went to see Governor Vandiver on February 15, 1962, about this program and he agreed to make additional funds available, making possible the continuance of the program.

On January 26, 1962, I was a member of a group which attended the American Medical Association's National Legislative Conference in Chicago.

I have attended as many of the District and County Medical Society meetings as possible.

Due to the good work done by physicians all over the state we managed to defeat, in the General Assembly, a bill to legislate podiatrists into the Blue Shield Plan in Georgia.

In my speech, made at the time of my installation as President, I named the following as our greatest needs:

- (1) Chronic Diseases and Health Care of the Aging:
We put Kerr-Mills Legislation into action in Georgia on January 1, 1962. We also have a permanent Committee on Aging made available by the Governor and the Legislature.

- (2) Mental Illness:

Great strides have been made in this field in the State of Georgia in the past three years—in fact, more than had been accomplished in the previous 30 years. We have opened a new intensive care unit in the State Hospital at Milledgeville. The Contract has been let and the ground broken (construction will begin

about September 1) for a new Mental Hospital on Briarcliff Road, Atlanta. This unit will be for training personnel and will be under the guidance of Emory University. Progress has also been made on the Mental Health Program in our State by the organization of Mental Health Societies sponsored by the County Medical Societies. This is a means of educating the public as to this great problem and the part the layman may take to help the program.

- (3) Reorganization of Committees:

This reorganization has been done and the committees are working effectively.

- (4) Supply of Physicians and Proper Placement:

Strides are continuing in this effort.

- (5) Intra-Membership Relations:

These have been strengthened and we are still in the process of bettering our membership relations and our public relations.

- (6) Cooperation with Other Organizations:

Our cooperation has definitely been strengthened through the establishment of formal liaison with many organizational groups.

- (7) Legislation — National and State:

Our legislation on both levels has worked very effectively and we have so far been able to accomplish our aims. We need a continued effort in this field.

I would like to take this opportunity to thank each member of the Executive Committee, the Council, and the other committees for the splendid cooperation they have given me because without their help, my job would have been impossible to accomplish. The great assistance given me by our Executive Secretary, Milton Krueger and by Jim Moffett, Assistant Executive Secretary, and Mrs. Catherine Wooten, Executive Assistant, and each member of the organization of the Medical Association of Georgia is gratefully acknowledged.

REFERENCE COMMITTEE RECOMMENDATION—Dr. Simonton's report was considered and the Committee would like to express appreciation for the time and energy expended by Dr. Simonton on behalf of the MAG during his year as President.

The President's report and the report of the Sub-Committee on Cancer were considered and the Reference Committee recommendation recommends that in the future the Advisory Committee to the State Aid Cancer Program be consulted before any changes in policy relative to patient care are undertaken, and that this information be made available to the MAG Sub-Committee on Cancer. The Reference Committee also recommends that the MAG Sub-Committee on Cancer request that every effort be made to see that funds are available to continue an adequate State Aid Cancer Program.

The problem of supply and proper placement of physicians was discussed and in this respect, the Reference Committee recommends that in the future the physicians in a local area be consulted for their opinion as to the adequacy of medical facilities available before placing a town on the approved list by the State Medical Education Board.

HOUSE OF DELEGATES ACTION—Adopted the report of the President as recommended by the Reference Committee and the additional recommendations of the Reference Committee on motion duly made and seconded.

President-Elect

THOMAS W. GOODWIN, M.D., *Augusta*

This past year has been a most interesting and instructive one for your President-Elect. This was the year

of training for me, of indoctrination into the trials and tribulations, as well as the obligations and responsibilities of the Presidency. From what I have learned, I must confess that I approach this task with considerable humility and trepidation. In our way of life responsibility goes with honor and this is as it should be. Let me assure you that I appreciate the honor which you have conferred upon me and that I feel the responsibility with which that honor is associated very deeply. During the past year I have attended all meetings of the Executive Committee except one, on this occasion I was providentially hindered from being present. I have also attended all meetings of Council and have attended the annual AMA Legislative Conference in Chicago.

I have also filled many speaking engagements—before civic clubs, church groups, and the like—and have tried to make the position of medicine clear. It seems to me that in this confused, atomic age we need to see clearly that what is happening to medicine is simply a symptom of the over-all sickness which is affecting our society as a whole. A sickness which manifests itself in the “get something for nothing” philosophy. Until we as doctors can make it clear that we still stand for the principles of individual enterprise, integrity and hard work and for the concept that every man has to work out his own destiny, we are going to continue to be plagued by the socialistic planners in Washington who seem more intent on changing a political philosophy than they are in anything else.

REFERENCE COMMITTEE RECOMMENDATION—Dr. Goodwin’s report is approved and he is commended for his service to MAG.

HOUSE OF DELEGATES ACTION—Adopted the report of the President-Elect as recommended by the Reference Committee on motion duly made and seconded.

Immediate Past President

MILFORD B. HATCHER, M.D., *Macon*

It is fitting that I express my appreciation to our President, Dr. Fred Simonton, efficient Secretary, members of the Headquarters Staff, and the Officers and Council for the manner in which all Boards were organized, committees functioned, and the recommendations made by your President last year were carried out. Many of these are covered in reports of others, which I will not repeat.

As we progress further, I feel that there should be more cooperation between members of the medical profession, legal profession, and the insurance industry. Therefore, I recommend that the MAG and the Insurance Council of Georgia form a working Council to discuss mutual problems. I further recommend that every effort be made for better liaison between the medical profession and the legal profession in settling liability problems at their inception.

I appreciate very much and wish to thank you again for allowing me the privilege of serving as your President and on your Council and Executive Committee. As I now join the ranks of Past Presidents, I feel that the MAG has chosen well its leaders for the future, and I remain optimistic concerning the affairs of the MAG.

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the report of Dr. Hatcher.

The Reference Committee recommends that a Committee or Sub-Committee be formed to work with the Health Insurance

Council of Georgia in promoting liaison between the physicians of Georgia, insurance companies and the state insurance commissioner.

HOUSE OF DELEGATES ACTION—Adopted the report of the Immediate Past President as recommended by the Reference Committee and the additional recommendation of the Reference Committee on motion duly made and seconded.

Supplementary Report of Immediate Past President No. E

INTERNSHIP REQUIREMENT FOR LICENSURE

MILFORD B. HATCHER, M.D., *Immediate Past President*

During the past few years it has become obvious that there is a change in medical practice. Actually the legal status of a physician to practice is governed by state laws. Now it is my understanding that to practice medicine legally in Georgia one has to have an acceptable M.D. degree and pass the prescribed examination (which is rather academic). It is my feeling that a year’s internship is of such vast importance for the future health of the people of Georgia that I recommend that this House of Delegates instruct its Legislative Board to take necessary action to see that a one year approved internship is satisfactorily completed before a license be granted to practice medicine in the state of Georgia.

REFERENCE COMMITTEE RECOMMENDATION—Dr. Hatcher’s Supplementary Report No. E concerning hospital training after graduation from medical school was discussed at length. The Reference Committee approves this Supplementary Report, but wishes to change the terminology to recommend that the House of Delegates instruct its Legislative Board to take necessary action to see that one year of hospital training in a hospital acceptable to the State Board of Medical Examiners is satisfactorily completed before a license be granted to practice medicine in the state of Georgia.

HOUSE OF DELEGATES ACTION—Adopted Supplementary Report of the Immediate Past President No. E: Internship Requirements for Licensure as recommended by the Reference Committee on motion duly made and seconded.

First Vice President

LINTON H. BISHOP, JR., M.D., *Atlanta*

The first Vice President has attended the Executive Committee meetings and Councils during the year. During the year, he participated freely in the discussions of the Executive Committee and at the direction of the Executive Committee did work helping to clarify the ad valorem tax situation of the Association. During the month of October the President was out of the country, and the first Vice President acted in the President’s behalf. He presided at the October meeting of the Executive Committee.

The Vice President recommends that the Bylaws be clarified as to whom shall be the presiding officer of the Executive Committee during times the President is out of the country or incapacitated and the Vice President is Acting President. The first Vice President also recommends that the first Vice President be made a voting member of the Executive Committee and suggests that this recommendation be forwarded to the Constitution and Bylaws Committee for appropriate action.

REFERENCE COMMITTEE RECOMMENDATION—The report of Dr. Bishop was received and carefully studied. The Reference Committee would like to commend Dr. Bishop for his diligent work

this past year on behalf of MAG. The Committee carefully studied the Constitution and Bylaws of MAG and interprets these as providing that the Vice Chairman of the Executive Committee will assume the Chairmanship of the Executive Committee in the event of absence or temporary disability of the President of MAG.

The Committee recommends that the suggestion that First Vice President be made a voting member of the Executive Committee be referred to the Constitution and Bylaws Committee for consideration and further action.

HOUSE OF DELEGATES ACTION—Adopted the report of the First Vice President as recommended by the Reference Committee on motion duly made and seconded.

Seventh District Councilor

R. W. FOWLER, SR., M.D., *Marietta*

The Seventh District Medical Society has experienced a very satisfactory year. We have had fall and spring meetings with good attendance, good scientific programs, and congenial fellowship.

The membership has cooperated with the legislative committee of MAG in contacting their respective legislators for the passage of bills sponsored by this body.

We also have been active on a national level and have cooperated in arousing sentiment against the King-Anderson Bill.

The Seventh District Medical Society has had no disciplinary questions. As far as we know all is harmonious in our district.

We have continued to increase our membership both to the MAG and to the AMA.

Below is a detailed record of our 1961 membership in comparison to our 1960 record.

Counties and Secretaries	Members December 31, 1961		Members December 31, 1960	
	MAG	AMA	MAG	AMA
Bartow				
Virginia D. Hamilton				
Cartersville	8	7	8	7
Carroll-Douglas-Haralson				
J. H. Beall				
Carrollton	35	29	33	26
Chattooga				
Joe A. Stewart				
Summerville	6	6	7	7
Cobb				
C. T. Henderson				
Marietta	84	78	81	74
Floyd				
Robert J. Black				
Rome	58	53	58	49
Gordon				
R. D. Walter				
Calhoun	9	8	9	7
Polk				
T. E. Cummings				
Rockmart	14	11	13	10
Walker-Catoosa-Dade				
John C. Ellis				
Rossville	32	23	30	25
Whitfield				
David A. Wells				
Dalton	33	24	37	23
	279	239	276	228

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee approves and commends the report of the Seventh District Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Seventh District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Eighth District Councilor

F. G. ELDRIDGE, M.D., *Valdosta*

Your Councilor has attended all meetings of the Council.

The Eighth District conducted a poll of members during the year regarding meeting sequences and places of meeting. Due to the distances involved, the following plan was evolved and passed at the regular October, 1961, meeting held in Jesup, Georgia:

In the future, only one meeting will be held, and this meeting will be convened at Jekyll Island, the time and date to be decided by a committee on arrangements composed of one member from each component society. Better attendance should result if week-end meetings are held and adequate programs arranged.

Counties and Secretaries	Members December 31, 1961		Members December 31, 1960	
	MAG	AMA	MAG	AMA
Altamaha				
James T. Nunnally, III				
Hazlehurst	10	9	7	6
Camden-Charlton				
J. O. Simmons				
Woodbine	8	8	—	—
Coffee				
C. S. Meeks, Jr.				
Douglas	14	6	13	6
Glynn				
J. L. Owens, Jr.				
Brunswick	44	40	45	40
South Georgia				
Thomas H. Smith, Jr.				
Valdosta	56	50	51	45
Telfair				
D. B. McRae				
McRae	8	6	8	6
Ware				
S. W. Clark				
Waycross	47	40	49	39
Wayne				
D. H. G. Glover				
Jesup	10	8	8	8
	197	167	181	150

Eighth District Vice Councilor

JAMES M. HICKS, M.D., *Brunswick*

We are proud to announce that Glynn-Brunswick Memorial Hospital has received its Accreditation for one year.

On the 8th of March we will have our approval for the expansion of our hospital, doubling its present capacity.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee approves and commends the Report of the Eighth District Councilor and Vice Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Eighth District Councilor and Eighth District Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

Ninth District Councilor

C. R. ANDREWS, JR., M.D., Canton

During the past year Ninth District has been represented at all the regular and called meetings of Council by the Councilor and Vice Councilor.

The Ninth District continues to be a strong and active district holding two excellent meetings in April and September of each year. It will be noted below that there has been some gain in comparative standing as of December 1961 as against December 1960 both with regard to MAG and AMA members.

It has been a pleasure to have served as Ninth District Councilor and I am happy to report that the Ninth District remains one of the stronger districts in the State.

Counties and Secretaries	Members December 31, 1961		Members December 31, 1960	
	MAG	AMA	MAG	AMA
Blue Ridge				
Thomas J. Hicks				
McCaysville . . .	10	6	9	5
Chattahoochee				
Cecil Miller				
Buford	20	16	20	17
Cherokee-Pickens				
D. T. Darnell				
Canton	13	11	14	11
Habersham				
George M. Tolhurst				
Cleveland	18	15	16	15
Hall				
C. J. Walker, Jr.				
Gainesville . . .	51	48	48	43
Jackson-Barrow				
A. A. Rogers, Jr.				
Commerce	18	13	17	12
Rabun				
John T. Norman				
Clayton	3	2	3	2
Stephens				
Irving D. Hellenga				
Toccoa	17	15	17	14
	150	126	144	119

Ninth District Vice Councilor

PAUL T. SCOGGINS, M.D., Commerce

The Ninth District has been represented by the Councilor or Vice Councilor or both at all meetings. We shall strive to carry out our duties during the coming year as we have during the past year.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee approves and commends the Ninth District Councilor and the Ninth District Vice Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Ninth District Councilor and the Ninth District Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

Tenth District Vice Councilor

M. A. HUBERT, M.D., Athens

Attended meetings of Council during past year. Attended the fall and spring Tenth District meetings. Hope to visit each County Medical Society in the district in the coming year.

Tenth District Councilor Addison Simpson, Jr., is currently at Mayo's Clinic and for this reason no Tenth District Councilor's report will be printed.

Counties and Secretaries	Members December 31, 1961		Members December 31, 1960	
	MAG	AMA	MAG	AMA
Crawford W. Long				
George Erwin				
Athens	51	42	49	40
Franklin-Hart-Elbert				
Wesley W. Harris				
Royston	22	16	23	17
McDuffie				
Ernest L. Cook				
Thomason	6	6	6	6
Oconee Valley				
L. K. Lewis				
Madison	12	8	13	9
Walton				
Steven Byars				
Monroe	10	9	12	10
Warren				
A. W. Davis				
Warrenton	2	—	2	1
Wilkes				
Harry Chevis				
Union Point . . .	11	8	11	7
	114	89	116	90

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee approves and commends the report of the Tenth District Vice Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Tenth District Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

Richmond County Councilor

HARRY D. PINSON, M.D., Augusta

During the year 1961-62, I have attended the Council meetings and served on the Insurance and Economics Board and as Chairman of the Subcommittee for Relative Value Study. I have made reports to my County Medical Society when indicated. I recommend that in the future we try to strengthen our legislative activity over the entire state. A need for this and the danger inherent in the lack of it was demonstrated during the 1962 State Legislature when the Podiatry bill was rushed through the House of Representatives and later many of the Representatives who had voted for it said they did not realize the doctors of Georgia were not in favor of this bill. I suggest that we encourage each Councilor and the President of each County Medical Society to keep in touch with the Representatives and Senators in each district and keep them informed of the desires of the Medical Association in regard to pending legislation which might be of concern to us.

Counties and Secretaries	Members December 31, 1961		Members December 31, 1960	
	MAG	AMA	MAG	AMA
Richmond				
W. N. Agostas				
Augusta	230	201	222	183

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee approves and commends the report of the Richmond County Medical Society Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Richmond County Medical Society Councilor as recommended by the Reference Committee on motion duly made and seconded.

Volunteer Health Agencies

ROBERT C. PENDERGRASS, M.D., *Chairman*

(See Reports Below).

Cancer Sub-Committee

ROBERT C. PENDERGRASS, M.D., *Chairman*

The sub-committee on cancer wishes to submit the following report:

Effective July 1, 1961, Dr. Murphy was directed by Dr. Venable to raise payments for hospital care of cancer state aid patients to 100 per cent of estimated cost. The meeting of the Sub-Committee on Cancer was held on August 12, 1961, and the budget discussed in detail. On September 9, 1961, another meeting was held. In addition to the members of the committee, other physicians present included W. J. Murphy, Julian B. Neel, Benham Stewart, Gray Fountain, Ralph Davis, Neal Yeomans, Menard Ihnen, and John L. Barner. Administrators of the Archibald Memorial Hospital, the Columbus Medical Center, Crawford Long Memorial Hospital and State Department of Welfare were present. Mr. Phil Cawthon addressed this meeting in regard to the Kerr-Mills bill which became effective in the State of Georgia as of January 1, 1962 and discussed the relationship between this new Medical aid for the Aged Act in its relationship to the present State Aid Cancer Program.

Your Chairman requested that Everett L. Bishop, Robert L. Brown, Enoch Callaway and Thomas Harold be added to the list of the original committee. Dr. Callaway unfortunately passed away before he had the opportunity to attend any further meetings. A meeting was held on December 9, 1961, at which time Dr. Wommock presided as Chairman. An invitation was sent to the hospital administrators to meet jointly with the Sub-Committee on Cancer and the problem of the budget for the State Aid Cancer Program was again discussed. It was pointed out that an additional \$165,000.00 would be required to carry the State Aid Program through January 30, 1962 but that an increased appropriation from \$400,000.00 to \$600,000.00 be needed for the following year. The Georgia Hospital Association presented such a resolution from their group.

The transfer of the Savannah Tumor Clinic to The Memorial Hospital in Savannah was discussed and approved.

On December 22, 1961, members of the Committee met with Gov. Vandiver and placed the full effects in his hands, requesting additional funds for operation

for the remainder of this year and increased appropriation for the following year. At the meeting on January 21, it was learned that funds could possibly be furnished for operating until June 30, 1962 but with no increase in the budget for the following year. Change in the rules for handling for the State Aid patients was discussed and Chairman Wommock appointed a committee consisting of Bishop, Brown and Mauldin to work with Dr. Murphy revising these rules.

Another meeting of the Committee was held on January 31, 1962, which included several members of the Commission on Cancer, several clinic directors, representatives from the Georgia Hospital Association and several hospital administrators. Dr. W. J. Murphy of the State Health Department, Dr. John Venable, Director, State Health Department were present, also, Mr. Krueger and Mrs. C. Wooten of the MAG. Dr. Venable reviewed the past history of the State Aid Cancer program and gave information on the budget. Additional money was provided by the Health Department and the Governor on the provision that no request be made for increasing the appropriation for the year beginning July 1, 1962. In other words, we would be permitted to operate for the remainder of this year if we would not ask the Governor for an increased appropriation for the following year. This was finally agreed to by those present. Many of us dissented. As it now stands, the cancer program will probably be in trouble by the middle of 1962-63 year, and some action will have to be taken to secure further funds. Many legislators have been very cooperative in approaching Governor Vandiver and Dr. Venable on this subject and what will happen in the future remains to be seen. A copy of the revised rules and regulations for conducting the clinic operations is included (see below).

In order to further assist in the financial phase of the operation of the State Aid clinics, an estimate of the amount to be spent by each clinic was to be prepared and a summary of these estimates was mailed to each clinic director on March 13, 1962. This was to assist the directors in holding their expenditures as close to this estimate as possible.

Supplementary Rules and Regulations

Georgia State-Aid Cancer Program

1. Policies relating to the re-certification of state-aid patients.

Generally speaking, the original certification refers only to the lesion for which the patient is referred. Subsequently, re-approval will be required for the care of some new and unrelated condition. Moreover, since the financial status of the patient may improve, routine re-approval at certain intervals is desirable.

- If the lesion for which a patient is referred proves to be non-malignant, the patient ceases to be a state-aid case. He is not eligible for further services unless re-approved.
- Patients who have received treatment for one type of malignancy may not return for the evaluation of some new and unrelated condition unless re-approved.
- Re-approval of skin cancer patients will be required routinely every three years.

- (d) After a period of three years, patients who remain under observation may not be re-admitted to the hospital unless re-approved.
2. Biopsies should be obtained on an outpatient basis if at all possible. This also applies to other diagnostic procedures.
 3. Hospitalization for diagnostic study is limited to three days. The three-day limit also applies to re-admissions for study purposes.
 4. Patients may not be admitted to the hospital more than three days prior to surgery; that is, not more than three preoperative days will be paid for.
 5. Readmission of patients following definitive therapy.
 - (a) Patients may not be readmitted to the hospital except for specific therapy which may be expected to provide significant palliation. Patients may not be readmitted for supportive therapy.
 - (b) Patients may not be readmitted without the knowledge and approval of the clinic director.
 - (c) Except for specific therapy as indicated under (a) above, patients with advanced cancer may not be readmitted without the prior approval of the Director of Cancer Control.
 6. Patients may be admitted for one day for a blood transfusion. For multiple transfusions, patients may be admitted for as many as three days.
 7. Patients may be admitted for not more than four days for chemotherapy.
 8. Patients may not be hospitalized for X-ray therapy. If a patient must be admitted for that purpose, payment will be made for hospital or domiciliary care at the rate of \$5.00 per day. Any exception to this policy must be approved in advance by the Director of Cancer Control.
 9. Patients may not be admitted for the treatment of benign conditions unrelated to the patient's cancer.
 10. The cancer clinics are not general diagnostic clinics and they are not expected to accept patients for study unless there is a clear indication of malignancy. In the absence of a reasonable expectation of malignancy, it is not permissible to admit patients for study merely to establish a diagnosis or to "rule out cancer."
 11. If it appears that a referred patient may be able to pay for examination or treatment, the clinic is under no obligation to accept the case. A re-appraisal of the patient's financial status may be requested.
 12. Hospital insurance must be collected and deducted from the patient's bill.
 13. Bills for services rendered are checked against the monthly clinical reports which must provide sufficiently detailed information to justify the charges which are made.

Approved by the State Board of Health March 1, 1962.

REFERENCE COMMITTEE RECOMMENDATION—(From Reference Committee recommendation concerning President's report)—The Presi-

dent's report and the report of the Sub-Committee on Cancer were considered and the Reference Committee recommends that in the future, the Advisory Committee to the State Aid Cancer Program be consulted before any changes in policy relative to patient care are undertaken, and that this information be made available to the MAG Sub-Committee on Cancer. The Reference Committee also recommends that the MAG Sub-Committee on Cancer requests that every effort be made to see that funds are available to continue an adequate State Aid Cancer Program.

HOUSE OF DELEGATES ACTION—Adopted the report of the Cancer Sub-Committee as recommended by the Reference Committee and the additional recommendations of the Reference Committee on motion duly made and seconded.

Mental Health Sub-Committee

MAURICE F. ARNOLD, M.D., *Chairman*

This committee has followed closely the action of the Governor and the Legislature in regards to Mental Health in the State of Georgia. It was noted that no outstanding changes in regard to the Mental Health Program were felt necessary. It is still under complete control of the Department of Health.

It is also worthy of note that the Legislature did not see fit to revise the complete Public Health code. The main item of interest to the Mental Health Committee was that the Legislature made no change in the status regarding a patient's ability to pay at Milledgeville. It was also noted that new buildings are being completed at Milledgeville State Hospital and at Gracewood in the very near future for carrying the bigger load of our mental patients. Another progressive step for Mental Health is noted. "Ground-Breaking" will start in October of 1962 for the new Mental Health Center to be on the property of the Georgia Alcoholic Center on Briarcliff Road, Atlanta, Georgia.

No recommendations are made from this committee.

REFERENCE COMMITTEE RECOMMENDATION—Reference Committee approves and commends the report of the Sub-Committee on Mental Health.

HOUSE OF DELEGATES ACTION—Adopted the report of the Sub-Committee on Mental Health as recommended by the Reference Committee on motion duly made and seconded.

Report of the Journal

EDGAR WOODY, JR., M.D., *Editor*

The 1961-62 Report of the Journal of the Medical Association of Georgia is submitted herewith:

Personnel

Since the last Annual Report, Mrs. Anne W. Kirkland submitted her resignation as Managing Editor. Her service to the Journal was outstanding and her resignation was accepted with regret. She was replaced by Miss Virginia Gaines, a graduate of the University of Georgia, School of Journalism.

There have been no additions to the staff of contributing editors during the past year. Our editors have been of tremendous help through their contributions of editorials, solicitation of desirable scientific papers for publication, and for their contributions to our feature page, "Current Clinical Concepts."

It was with much regret that the editor accepted the resignation of Dr. Ted F. Leigh as Staff Photographer. Over the years his photographic contributions have done much to enhance the attractiveness of Journal

covers. His resignation was prompted by increasing demands of his time from many sources. The Journal staff will always feel indebted to Dr. Leigh for the service he has rendered toward the development of our publication.

Conferences

In October of 1961 the editor and managing editor attended the Conference of the State Medical Journal Advertising Bureau which is held in Chicago every other year. An interesting and instructive program was presented which helped us in the solution of many of our publication problems at the Journal.

State Medical Journal Advertising Bureau

In June of 1961 the Medical Association of Georgia was invited to become a stockholder in the State Medical Journal Advertising Bureau, a non-profit organization. The Council of the MAG accepted the invitation and purchased one share of stock from the Missouri Medical Association for the sum of \$200.00. This money is refundable if and when the MAG wishes to transfer its share to some other state association. There are four other state associations holding stock in this corporation whose function is the solicitation and screening of pharmaceutical advertising for all of the state medical journals over the country.

Your editor serves as a member of the Board of Directors and as a member of the Advertising Committee of this organization.

Content

While our advertising copy has remained significantly reduced during the past 12 months, there is considerable evidence that an upturn is in sight for the year 1962. While no one expects advertising volume to return to the 1958-59 level, there are signs of a leveling off at a higher level than we now have. In spite of these advertising cutbacks, the Journal has managed to maintain its previous volume and quality of editorial copy. The number of unsolicited scientific papers submitted for publication continues on the upswing. This is an encouraging sign.

The feature pages which include the President's Letter, the Mental Health Page, the Heart Page, the Cancer Page, the Legal Page, Current Clinical Concepts, Physicians' Bookshelf and Abstracts of Georgia Authors remain popular with our readers.

Top of the News, the yellow insert page, continues to provide a vital function in the presentation of fresh vital news of the Association in concise telegraphic style.

The Journal has continued its use of supplements mailed under the same cover with the Journal. In this way special attention is called to important activities currently being sponsored by the MAG.

Format and Typography

During the past year many helpful services have been rendered by Mr. John McKenzie in the area of typography toward the betterment of Journal design. Mr. Joe Jackson and Miss Kathleen Mackay of the Emory University Department of Medical Illustration, have been very helpful in the production of our cover illustrations. They have moved in to fill the large gap resulting from the resignation of Dr. Ted Leigh from the Journal staff.

No radical departures in typography have been made

during the past year though small changes and improvements are continually being made.

Thanks are due to Mr. Milton Krueger, Mr. Jim Moffett and the other members of the Headquarters Office Staff who have been of great assistance during the past year in supplying news of the activities of the Association for the columns of the Journal.

A continuing effort has been made to produce a Journal of superior quality and one which consistently reflects the policies and programs of the Association. Any constructive suggestions for improvement of your publication will always be welcomed by the Editor.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee approves and commends the report of Dr. Woody. The Committee wishes to express appreciation to Dr. Woody for the excellent job he is doing in editing the Journal of the Medical Association of Georgia.

HOUSE OF DELEGATES ACTION—Adopted the report of the JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA as recommended by the Reference Committee on motion duly made and seconded.

It was moved by Chairman of Reference Committee No. 1, Tully T. Blalock, Atlanta, and duly seconded that the report of Reference Committee No. 1 be approved as a whole and it was so ordered.

Report of Reference Committee No. 2

A. J. Waters, M.D., Chairman

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 2 met at 8:00 A.M. in Room 450, DeSoto Hotel, Savannah, Georgia, May 7, 1962. Following members of the Committee were present: A. J. Waters, Augusta, Chairman; John D. Tate, Rome, Vice Chairman; I. D. Hellenga, Toccoa, Secretary; W. Earl Lewis, Macon; W. E. Barfield, Augusta; Bruce Swain, Jr., Clarkesville; J. W. Kelley, Griffin; David A. Wells, Dalton; and L. H. Griffin, Claxton.

Secretary

JOHN T. MAULDIN, M.D., Atlanta

The work of the Medical Association of Georgia from the Secretaries viewpoint has made satisfactory progress during the past year. I am happy to report that the State Legislature and Governor Vandiver saw fit to place the State Commission on Aging on a permanent basis. The new body will be activated on July 1st in new quarters and with a permanent Executive Secretary. I have been fortunate to be able to help with the activities of our Legislative Committee both in state and national legislation. The need for an MAG equivalent to AMA's AMPAC is urgent. Every doctor in Georgia should participate and I intend to work even harder next year to help establish an effective organization.

I have made several trips to county and district medical societies and attended several civic groups and

related organizational meetings during the year as MAG's representative. The major out-of-state meetings were as follows: AMA House of Delegates in New York during June, 1961; AMA Interim Meeting in Denver during November, 1961; attended the Little White House Conference in Washington, D. C.; attended HEW Regional Meeting on Aging in Nashville, November 9-10; attended AMA's Legislative Conference in Chicago, January 26-27, 1962; attended regional meeting of Proposed Blue Shield Senior Citizens Plan on February 5th; testified before the Ways and Means Committee in Washington, D. C. in August, 1961 presenting MAG's testimony in opposition to King Bill.

The reorganization of MAG and the Boards with related Committees under each Board has been a step in the right direction. This has improved coordination and will enable MAG to present a united front to a wider variety of activities.

Hospital Medical Council

This organization has continued active. Seven hospitals were inspected during the year and one hospital problem mediated. It is anticipated that the Welfare Department's inclusion of the Council standards in its program for the aging will increase the Council workload. The Medical Association of Georgia should be especially proud of this organization's work because Georgia is the only state in the United States that has such a program of standards for smaller hospitals.

The Medical Association of Georgia has continued to operate the Medicare program in Georgia under contract with the Department of the Army. This contract has been renewed with the approval of the Executive Committee in February of this year. There were only minor changes in the contract.

On recommendation of the Review Board Chairman and approval of the Executive Committee, rules have been changed so that each Review Committee member will be elected for a term of three years with one member added each year. This was done in order to assure continuity and experience of each Review Board. During the year 1961, Medicare paid 8,507 claims to doctors over the state amounting to \$674,396.50. This amount was approximately \$50,000.00 more than was paid for the comparable period of 1960. The nine local Medicare Review Boards in Georgia adjudicated 331 cases of special nature over the year. At present the Medicare office is experiencing a 28 per cent send back rate.

Kerr-Mills Program

The enabling Legislation to activate the Kerr-Mills program in Georgia was passed by the State Legislature in the 1961 session. Money became available in July, 1961 and the program was activated on January 1, 1962. The Medical Association of Georgia is participating on the basis of a contract approved by the Council on October 8, 1961 between the Medical Association of Georgia and State Welfare Department. On the basis of this contract the Medical Association of Georgia advises with the Welfare Department, first, as to the standards and expansion or contractions of the program. Second, that a patient's illness falls within the rules and regulations of the program, and hospital stay is commensurate with diagnosis. On the basis of three short months' experience as Medical Director of

this program, I can say that the regulations have proven practical and that the acceptance and cooperation of both physicians and hospital has been excellent. It is anticipated that the passage of a bill by Congress in March, 1962 will enable the program to expand in the near future.

Headquarters Office

As Secretary I have coordinated the administrative problems of the Headquarters Office, advised on administrative policy and methods of office operation, handled the correspondence on matters related to medical policy not within the jurisdiction of other officers and committees, and advised the staff on other pertinent matters. The Headquarters Office has functioned well and has been most cooperative due to the foresightedness and excellent judgment of the Executive Secretary, Mr. Milton Krueger.

Headquarters Building

The Headquarters building has been used as a meeting facility at least twice a week by MAG and allied organizations. On occasion, the facilities have accommodated three simultaneous meetings without conflict. No major repairs have been necessary during the past year. It is recommended that a stove and sink be installed during the forthcoming year to facilitate the serving of lunches.

The office space has proven adequate, pleasant and efficient. The building as a whole has provided a center for MAG's state-wide activities and has been an adequate background for the enhancement of the Association's sphere of influence.

MAG Membership

Active	2577
Active Dues Exempt	381
Service Members	47
Associate	20
TOTAL	3025

Summary

In summary, I wish to express appreciation for the cooperation of the officers and members of the Medical Association of Georgia, particularly Dr. Fred Simonton, President; Dr. George Alexander, Chairman of Council. I have not encountered a single individual who was not willing to resolve his problems by frank and open discussion. All of the recommendations that I have for the past year have been discussed with Committee and Board Chairmen within whose jurisdiction they fall.

REFERENCE COMMITTEE RECOMMENDATION—This report was approved and commended. The services of our Secretary as representative of the Association under the provisions of the Kerr-Mills Act is highly appreciated. The work of the Headquarters staff cannot be over estimated.

HOUSE OF DELEGATES ACTION—Adopted the report of the Secretary as recommended by the Reference Committee on motion duly made and seconded.

Acting Treasurer

(Oct. 1961-Jan. 1, 1962)

J. G. McDANIEL, M.D., *Atlanta*

Due to the death of MAG Treasurer C. Raymond Arp in October, 1961, I was appointed Acting MAG

STATEMENT OF ASSETS AND LIABILITIES — BY FUNDS

The Medical Association of Georgia
Year Ended December 31, 1961

ASSETS

GENERAL FUND

Cash			\$ 3,297.92
Cash in savings accounts (including \$3,600.00 restricted for property repair and replacement)			23,600.00
United States government securities — at cost or redemption prices (approximately equal to market)			5,000.00
Accounts receivable:			
Due from United States government:			
Medicare program:			
Excess of claim expenses over professional claim fees received		\$ 8,086.78	
Advertisers of The Journal	\$2,593.58		
Other accounts	625.00	3,218.58	11,305.36
Property and equipment—on the basis of cost:			
Land—mortgaged			80,000.00
Buildings—mortgaged		\$110,954.72	
Furniture and equipment		22,322.21	
		\$133,276.93	
Less allowances for depreciation		24,994.75	108,282.18
			<u>\$231,485.46</u>

ABNER W. CALHOUN LECTURESHIP FUND

Cash	\$ 163.21	
Corporation stocks—at cost (quoted market prices \$5,390.13)	6,101.85	6,265.06

MEDICARE FUND — DEPARTMENT OF THE ARMY

Cash	\$ 19,180.06	
Due from United States government:		
Service fees paid to physicians and dentists	65,819.94	85,000.00
		<u>\$322,750.52</u>

LIABILITIES AND EQUITIES

The Medical Association of Georgia
Year Ended December 31, 1961

GENERAL FUND

Liabilities:		
Note payable to insurance company, \$4,000.00 installment, with interest at 5%, due on January 1, each year— secured by loan deed on land and buildings	\$ 27,000.00	
Membership dues collected in advance	426.00	\$ 27,426.00
Fund equity:		
Restricted for regular operating purposes	\$ 20,000.00	
Restricted for lecture expenses	660.01	
Unrestricted	183,399.45	204,059.46
		<u>\$231,485.46</u>

ABNER W. CALHOUN LECTURESHIP FUND

Fund equity		6,265.06
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MEDICARE FUND — DEPARTMENT OF THE ARMY

Advance from United States government		85,000.00
		<u>\$322,750.52</u>

STATEMENT OF FUND EQUITIES

The Medical Association of Georgia
Year Ended December 31, 1961

	Balance Jan. 1, 1961	Income in Excess of Expenses	Fund Transfers	Balance Dec. 31, 1961
GENERAL FUND				
Restricted for operating purposes	\$ 20,000.00	\$ -0-	\$ -0-	\$ 20,000.00
Restricted for lecture expenses	395.04	-0-	264.97	660.01
Unrestricted	171,579.49	11,819.96	-0-	183,399.45
	<u>\$191,974.53</u>	<u>\$ 11,819.96</u>	<u>\$ 264.97</u>	<u>\$204,059.46</u>
ABNER W. CALHOUN LECTURESHIP FUND				
	6,265.06	264.97	264.97*	6,265.06
TOTAL	<u><u>\$198,239.59</u></u>	<u><u>\$ 12,084.93</u></u>	<u><u>\$ -0-</u></u>	<u><u>\$210,324.52</u></u>

*Indicates red figures.

STATEMENT OF INCOME AND EXPENSES — BY FUNDS

The Medical Association of Georgia
Year Ended December 31, 1961

	General Fund	Abner W. Calhoun Lectureship Fund
INCOME		
Medical Association of Georgia dues	\$102,500.00	\$ -0-
Advertising — The Journal	38,053.57	-0-
Subscriptions — The Journal (non-members)	390.50	-0-
Exhibitors' fees — 1961 annual meeting	9,800.00	-0-
Interest Income	1,185.00	-0-
Dividends — corporate stocks	-0-	278.92
American Medical Association refund	608.13	-0-
Miscellaneous	5.38	-0-
TOTAL INCOME	<u>\$152,542.58</u>	<u>\$ 278.92</u>
EXPENSES		
Fixed allotments	\$ 8,949.69	\$ -0-
Association office	72,017.21	-0-
Medical Association of Georgia committees	9,386.64	-0-
1961 annual session	8,174.76	-0-
The Journal	42,011.83	-0-
Trustees' fees	-0-	13.95
Furniture and fixtures abandoned	182.49	-0-
TOTAL EXPENSES	<u>\$140,722.62</u>	<u>\$ 13.95</u>
EXCESS OF INCOME OVER EXPENSES	<u><u>\$ 11,819.96</u></u>	<u><u>\$ 264.97</u></u>

Treasurer by the Executive Committee of Council until a new Treasurer could be appointed and approved by Council. I served in this capacity until January 1, 1962, at which time John S. Atwater, M.D., Atlanta, was appointed MAG Treasurer.

During my 3 months' tenure as Treasurer, MAG finances came under my jurisdiction and I reported monthly to Executive Committee of Council and Council on the fiscal status of the Association.

The official audit attached below for the year ended December 31, 1961 completed my term of office in the position of Acting Treasurer. It was my privilege to

turn these matters over to Dr. Atwater on January 1, 1962 and his report is given below.

Treasurer

(Jan. 1, 1962-)

JOHN S. ATWATER, M.D., *Atlanta*

The report of the auditors, Ernst and Ernst, is attached. This audit covers the period ending the calendar year December 31, 1961. It is noted that the Association is in good financial condition. Expenses

have increased yet income has been such as to meet these needs.

Regrettably in October, 1962 the former Treasurer of the Association, C. Raymond Arp, died. He had performed his duties well and his death was a genuine loss to all of us. J. G. McDaniel capably acted as Treasurer in the interval from Dr. Arp's death through December 31, 1961.

On January 1, 1962 I took office as Treasurer. It is my sincere desire to conduct the business of the Treasury in a manner consistent with my excellent predecessors. I should like to thank all who have been of help in this transition period, especially Miss Thelma Franklin, our efficient bookkeeper.

ERNST & ERNST
FIRST NATIONAL BANK BUILDING
ATLANTA 3, GA.

Chairman of the Council
The Medical Association of Georgia
Atlanta, Georgia

We have examined the statement of assets and liabilities of The Medical Association of Georgia funds at December 31, 1961 and the related statements of income and expenses and equities for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying statement of assets and liabilities - by funds and the statements of income and expenses - by funds and fund equities present fairly the financial position of The Medical Association of Georgia at December 31, 1961, and the results of its operations for the year then ended in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Atlanta, Georgia
February 20, 1962

Ernst + Ernst

REFERENCE COMMITTEE RECOMMENDATION—The report of the Treasurer and Acting Treasurer was approved and commended. Recognition of the sudden death of Dr. C. Raymond Arp and of his inestimable services to the Association were made by the Committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the Treasurer and the Acting Treasurer as recommended by the Reference Committee on motion duly made and seconded.

Speaker, House of Delegates

J. FRANK WALKER, M.D., *Atlanta*

One hears with increasing frequency the charge that organized medicine is not democratic or representative of the average practicing physician. That this charge is unfounded is proved by the entirely democratic form of legislative government reflected in the House of Delegates of the Medical Association of Georgia. Binding MAG policy is established by this body, composed of delegates elected at the local county medical society level. Although even the smallest society is entitled to at least one delegate, representation is otherwise based on the active membership of the local society. The body of men who comprise the House can speak with authority, for collectively they represent every physician in the state.

The success of such a democratic form of government depends, of course, on individual initiative and active participation. It is a matter of concern that some of the smaller societies still do not avail themselves of representation. Some delegates, every year, ignore the all-important voting second session of the House of Delegates.

Every action of the 1961 House of Delegates has been followed within the appropriate Board, Committee or Council to assure proper disposition of each.

Vice-Speaker Joe Mercer is commended for his helpful consultation and cooperation.

The reference committees of the House diligently investigate the various matters referred to them at the first session. Any member of the MAG, not just delegates, is invited to, and, indeed, is obligated to, appear before these reference committees to furnish specific information and clarification, particularly on issues of individual interest or knowledge.

Vice-Speaker, House of Delegates

JOSEPH B. MERCER, M.D., *Brunswick*

The Vice-Speaker of the House of Delegates has participated in the functions of Council and Committees during the past year to the fullest extent possible. Under the able leadership of J. Frank Walker, the House of Delegates' desires were expressed in Council meetings. It is the opinion of the Vice-Speaker that the intent of the House of Delegates was given full consideration in every decision made by Council. No recommendations for any changes are needed.

REFERENCE COMMITTEE RECOMMENDATION—The report of the Speaker and Vice Speaker was approved and commended. The work of Dr. Walker and Dr. Mercer in planning the entire session is recognized and highly commended.

HOUSE OF DELEGATES ACTION—Adopted the report of the Speaker and the Vice Speaker as recommended by the Reference Committee on motion duly made and seconded.

Annual Session

PETER HYDRICK, M.D., *Chairman*

The Medical Association of Georgia having selected Savannah and the De Soto Hotel as the site of the 1962 Annual Session, the Chairman of Annual Session and his Committee met in Savannah the latter part of 1961. The meeting hall facilities of the De Soto Hotel are adequate and can be divided among the various specialty groups for the various scientific meetings, leaving two large meeting halls for main scientific meetings and the business meetings. However, the remaining space for commercial exhibits was not the best unless changes in the booth size were made. Due to the criticism from the exhibitors at the last Savannah meeting at the De Soto, and it was justified, a request to use 4x6 booths instead of 8x10 booths was presented and passed by Council. Using this size booth we are able to arrange a perfect maze of booths direct to both main meeting halls which will place all doctors past all commercial exhibits and thereby should satisfy all exhibitors. The Committee was also looking forward to the meeting to be held in Jekyll in 1963, where the Aquarama will house the exhibitors and the main meeting hall, and here too it will be difficult, if not impossible to use 8x10 booths. If the experiment in Savannah with hospital type exhibits is a success then it would be the Committee's desire to do the same at Jekyll. In addition to laying out the floor plans for the meeting at the De Soto, the Committee met with the representatives of the various specialty groups and organized a program inasmuch as assigning times and

meeting rooms and combining various groups together to present an interesting and compact scientific meeting and complying with Council's request for a full afternoon of no scientific meetings so that the doctors in attendance could sightsee, play, shop or rest.

A second trip to Savannah was made in February of this year. At this time the Board met with the local arrangements committee and the Ladies' Auxiliary representatives. All phases of local arrangements were discussed and all areas were assigned workers. The Ladies' Auxiliary discussed their problems and their desires and it was the opinion of the Committee that everything was worked out to the satisfaction of all concerned. A third trip to Savannah is planned and at this time the Committee will attempt to see that everything is in order and take care of anything not covered in the previous two meetings.

In October of last year a detailed study of Jekyll Island facilities was made in anticipation of the 1963 meeting. The Aquarama will adequately house a maze of 4x6 commercial exhibits and one large meeting hall, but due to acoustics all other meetings will necessarily have to be held in the motels on the beach. It is therefore requested that the programming of the scientific portion of this meeting be concentrated on the idea of one central meeting with a majority of the membership in attendance with the much smaller specialty groups meeting in the meeting halls provided by the motels. If this meets with the approval of the House of Delegates the details can be worked out with the program committee.

It appears that the meeting in Savannah is all set and ready and the Committee hopes that its experiment with the hospital size exhibits is successful as it will facilitate future meetings in areas that do not have adequate convention facilities. In accordance with the most quoted clinche of our times, "it is not what the Medical Association can do for you but what you can do for the Medical Association." Our answer to this is that the members should support the annual meeting by their attendance and by visiting the commercial exhibits which in effect make the annual session possible.

REFERENCE COMMITTEE RECOMMENDATION—It was moved that the report be approved and commended; an error indicating the size of booths as 4 x 6 ft. is corrected to indicate that they are 6 x 6 ft. It is felt that the methods and arrangements worked out by the Board with respect to the limited exhibit space was very satisfactory, the pharmaceutical representatives having expressed satisfaction with the present type hospital displays.

HOUSE OF DELEGATES ACTION—Adopted the report of the Annual Session Board as recommended by the Reference Committee on motion duly made and seconded.

Constitution and Bylaws

W. G. ELLIOTT, M.D., *Chairman*

This Board has had one recommendation referred to it from the Annual Meeting of the House of Delegates in 1961. This recommendation is as follows:

To change the Bylaws of the Medical Association of Georgia, so that if the President of the Medical Association of Georgia were to become incapacitated, he would be succeeded by the Chairman of Council for the remainder of the year.

When this recommendation was made, the idea was to have some one promoted to the Presidency who

knew the workings of the Medical Association of Georgia in case something happened to the President, as death, resignation, or some other incapacity. The idea was good but this had already been taken care of at the same Session of the Medical Association of Georgia House of Delegates in 1961. The Constitution and Bylaws were changed so that the Vice Presidents would be made acquainted with the workings of the Association, and would be better qualified to take over the Presidency if necessary. (Chapter VI, Section 3).

All members of the Board of Constitution and Bylaws of the Medical Association of Georgia were contacted by mail, concerning this matter, and it is unanimous that the Constitution and Bylaws concerning the matter of who succeeds to the Presidency in case the President becomes incapacitated by death, resignation, or otherwise, should be left as it is.

We think there should be no change at this time, and so recommend.

No other problems have been referred to this Board.

REFERENCE COMMITTEE RECOMMENDATION—It was moved that the report be approved and commended.

HOUSE OF DELEGATE ACTION—Adopted the report of the Constitution and Bylaws Board as recommended by the Reference Committee on motion duly made and seconded.

Governmental Medical Services

LUTHER H. WOLFF, M.D., *Chairman*

Pursuant to the reorganizational plan inaugurated at the House of Delegates Meeting in April 1961, the following sub-committees were classified under the Board of Governmental Medical Services:

1. School Child Health
2. Maternal and Infant Welfare
3. Rehabilitation and Crippled Children.
4. Disaster Medical Care
5. Public Health

These Sub-committees were duly appointed by the Executive Committee of Council.

It soon became apparent that the grouping of Rehabilitation and Crippled Children affairs under one sub-committee was not workable, so that, with the approval of the Executive Committee, separate Sub-committees for Rehabilitation and Crippled Children were set up. In addition, at the request of the Chairman of the Sub-Committee on Maternal and Infant Welfare, two divisions of this Sub-committee were set up, one dealing primarily with Infant Welfare and the other with Maternal Welfare.

With these changes having been accomplished, an organizational and planning meeting of all Sub-Committee Chairmen was held at the MAG Headquarters on September 10, 1961. This meeting proved to be quite fruitful in that it demonstrated not only the advantage of having closer liaison between the various working Sub-Committees and Council, but also the opportunity of better cooperation and understanding between the various Sub-Committees, having more or less overlapping functions and projects.

During the past year the various Sub-Committees have met and have made plans and undertaken projects which have done a great deal to further the work of MAG. The Sub-Committee on Disaster Medical Care has been particularly active in its area of planning, as have many of the other Sub-Committees.

In general, it is the opinion of the Chairman of the Board of Governmental Medical Services that the reorganization of committees under the Board system is a decided improvement. The advantages mainly accrue from closer liaison between working committees and Council, and from better coordination and direction of committees having overlapping projects and functions.

REFERENCE COMMITTEE RECOMMENDATION—This report was approved and commended with appreciation to Dr. Luther Wolff for his excellent direction of the multiple Sub-Committees.

HOUSE OF DELEGATE ACTION—Adopted the report of the Governmental Medical Services Board as recommended by the Reference Committee on motion duly made and seconded.

Maternal and Infant Welfare Sub-Committee

EUGENE L. GRIFFIN, M.D., *Chairman*

There were two meetings of the Section on Maternal Deaths and two meetings of the Section on Perinatal Mortality. The two professors and heads of departments of obstetrics were ex-officio members.

A total of 75 maternal deaths have been reviewed and appropriate letters sent. The section members are concerned that in 14 or more prenatal care was inadequate or entirely lacking. There were four cases of ruptured uterus, and at least three cases in which the cause was inadequate blood replacement. Septic abortions continue to contribute heavily as a cause of death. The three or four cases of myocarditis are causing interest. The percentage of autopsies is increasing, but unfortunately the reports are not always included. An intensive effort will be made to obtain more of these reports.

In addition to review of deaths, the Section on Maternal Deaths has directed efforts toward making available both the Medical College and Emory University toxemia regimes. It has also established a relationship with the Georgia Medical Osteopathic Association through its president with regards to individual members signing maternal death certificates, but failing to reply to questionnaires.

The Section on Perinatal Mortality has made a fine start in undertaking a study of fetal and neonatal deaths in which prematurity is a factor. This is a sampling study, so only between 150 or 200 cases will be queried. So far, participation has been excellent despite the detailed questionnaires which seem necessary at this point.

Prematurity was selected since it accounted for 25 per cent of the leading causes of death in 1959, the latest figures available at the time of the meeting. Other leading causes were asphyxia, 25 per cent, birth injuries 12 per cent, congenital malformations 11 per cent and infections nine per cent.

The entire Sub-Committee was saddened by the untimely death of one of its members, Howell Wasden.

REFERENCE COMMITTEE RECOMMENDATION—This report was approved and commended. The Reference Committee expresses its concern over the increased rate of septic abortion and over failure of physicians to complete questionnaires with reference to maternal deaths.

HOUSE OF DELEGATES ACTION—Adopted the report of the Maternal and Infant Welfare Sub-Committee as recommended by the Reference Committee on motion duly made and seconded.

Public Health Sub-Committee

R. W. EDENFIELD, M.D., *Chairman*

The chairman of this committee has kept in touch with the Public Health Program in the state and feels that it is serving the community satisfactorily. No specific problems or issues have been brought to our attention. The committee plans to keep in touch with the Public Health Program and to advise and suggest to the State Health Department as specific issues come up.

REFERENCE COMMITTEE RECOMMENDATION—This report was approved and commended.

HOUSE OF DELEGATES ACTION—Adopted the report of the Public Health Sub-Committee as recommended by the Reference Committee on motion duly made and seconded.

Disaster Medical Care Sub-Committee

EDGAR M. DUNSTAN, M.D., *Chairman*

The activities of this Committee for the year 1961-1962 may be summarized as follows:

1. Continued in an advisory capacity to the Georgia Civil Defense Health Services on medical civil defense matters. Dr. Lester M. Petrie, Deputy Director of the Georgia State Civil Defense Health Services has been appointed a member ex-officio of this Committee, and Vice-Chairman. This establishes constant liaison with the Civil Defense Health Services activities of the State Health Department and State Civil Defense.
2. Dr. Petrie participated in the meeting of Health Mobilization Representatives from the various state health departments in the HEW Region IV. This helps to coordinate the disaster medical care activities of Georgia with those of the surrounding states. It is hoped that similar meetings can be held each year to carry on this coordination function which had previously been performed by the Implementation Committee of the States in the old OCDM Region III.
3. Continued to participate for the sixth consecutive year of instruction to Senior Dental Students at Emory University School of Dentistry in the course on Catastrophic Injuries and Diseases.
4. Your Vice-Chairman represented the Medical Association of Georgia and the Georgia Department of Public Health at the Twelfth Annual County Medical Societies Conference on Disaster Medical Care under the auspices of the American Medical Association in Chicago, November 1961.
5. Participated in field trials of class-room instructions, using the Medical Self-Help Training Kit, in the Atlanta Metropolitan Area in the late spring and early summer.
6. At the invitation of the Department of Defense, your Vice-Chairman served as an instructor at the Eastern Training Center Workshop in Brooklyn for Representatives from the Eastern States (representing state medical societies, state health departments, state education departments, and state civil defense). Dr. John Wilson represented the Medical Association of Georgia; Mrs. Kells Boland represented the MAG Auxiliary, as students at a

similar workshop for Central states, including Georgia, at Battle Creek, Michigan, in December. The other Georgia representatives at the Battle Creek Workshop were Dr. James Owen (Department of Education), Mr. George Watson (Department of Health), Mr. Jack Grantham (State Civil Defense).

Dr. Dunstan accepted appointment as Chairman, and Dr. Petrie as Vice-Chairman, of the Georgia State Medical Self-Help Training Advisory Committee. The other members of the Committee were the individuals who participated as students at the Battle Creek Workshops. The American Red Cross is represented by Mr. Charles C. Rice. This Committee has collaborated with the Medical Association of Georgia Committee on Disaster Medical Care in preparing the State Plan for Medical Self-Help Training, a summary of which was published in the February issue of Journal of the MAG.

The Disaster Medical Care Committee is also collaborating with the Medical Self-Help Training Committee in formulating plans for disaster medical care. A series of articles concerning these plans is appearing in current issues of the Journal of the MAG. When the Plans have been completed the Committee expects to publish the complete Plan under one cover.

It is considered that the Medical Self-Help Training contains basic information which every physician must know as background material for his further planning and training in disaster medical care.

7. There has been little progress in the census of health manpower personnel.
8. The Committee has had one formal meeting, on Sunday, October 22, at the Medical Association of Georgia headquarters, attended by nine MAG members, as well as invited guests from the American National Red Cross, Georgia Hospital Association, and the Georgia Department of Public Health.

The Committee at this meeting recommended to the Council that a "state-wide meeting of Civil Defense be held as soon before January 15 as possible and that this meeting be held on a Sunday. It was further recommended that in addition to all licensed M.D.'s being invited that the Council determine which organizations in the Health and Civil Defense field would be asked to send representatives. The Committee also recommended that a Civil Defense Emergency Hospital be displayed at this meeting. The Committee then voted to recommend that Fred Simonton, M.D., preside over this statewide meeting. It voted to program the balance of the meeting in the following order:

1. Opening remarks by Edgar M. Dunstan—5 minutes.
2. Welcoming remarks by General Hearn — 5 minutes.
3. Strategic briefing by a speaker to be sent by the Office of Civil Defense and that this speaker be sent down at the expense of the Office of Civil Defense — 1 hour.
4. Medical Self-Help program and kit.
 - (a) AMA support by Dr. Gerald Dorman — 15 minutes.
 - (b) AMA Auxiliary support by Mrs. Frederick Stephens — 15 minutes.
 - (c) Demonstration of kit including information on Public Health criteria on radioactive fall-

out and shelter by Major James D. Clark — 1 hour.

5. National and State Resources and Leadership Roles by Dr. Petrie — 1 hour.
 - (1) Civil Defense Emergency Hospitals
 - (2) Manpower Census.
 - (3) Proposed implementation in Georgia.

RECOMMENDATIONS

The Committee recommends that:

1. A statewide meeting of medical leaders from every local society be held on professional responsibilities of disaster medical care.
2. Continued full statewide cooperation, including local medical sponsorship and leadership in the Medical Self-Help Training program, be given.
3. Reactivation and support of community hospital administrators and district health departments in establishing in every local hospital and health department an effective census of health manpower personnel available in the event of disaster.
4. The composition of the Disaster Medical Care Sub-Committee be continued as at present and the advisory coordinating and leadership functions of the Committee be continued.

REFERENCE COMMITTEE RECOMMENDATION—This report was approved and commended. It is urged that its recommendation be carried out, particularly with regard to medical sponsorship and leadership in the field of disaster aid.

HOUSE OF DELEGATES ACTION—Adopted the report of the Disaster Medical Care Sub-Committee as recommended by the Reference Committee on motion duly made and seconded.

School Child Health Sub-Committee

JOHN L. BOWEN, M.D., *Chairman*

The School Child Health Committee has as its primary interests and activities for 1962 the following:

Maintenance of contact with local County Medical Societies. We requested by letter that each Society designate one man as chairman of its School Child Health Activities, so this committee would have direct contact with this "keyman" in carrying any proposed programs to the local levels.

An all-out effort, as endorsed by the AMA, to cooperate with the President's Council on Youth Fitness; more especially in that phase which relates specifically to health examinations of children and youth.

We are encouraging, through our representatives at the local County Medical Society level, the establishment of school health programs based on the recommendations of the President's Council and the National Committee on School Health Policies, as adapted to local conditions. We will provide the local committees with specific recommendations as we maintain liaison between them and the State and National Health Organizations.

Two members of this committee serve on the committee to study the possibility of developing centers for the functional appraisal of multiple handicapped children, which committee meets at the State Health Department.

Attendance by a member of this committee, Dr. Jack Hughston, to the third National Conference on the

Medical Aspects of Sports at Denver, Colorado in November, 1961.

Again in 1961, this committee sponsored a post-graduate course in The Medical Aspects of Sports for coaches, physicians, trainers, and educators. This was held in Macon, Georgia on August 11th and 12th, 1961. This course has been well attended and we plan continued sponsorship. Another such course is being planned for the summer of 1962.

Helping have the newsletter "Medicine in Sports" mailed to High School Coaches and Team Physicians.

A survey of the existent facilities for the evaluation or care of handicapped children throughout the state. This information will be sent to county Chairmen by letter, if a more detailed report cannot be published for wider distribution.

Provision at county and local levels for physical examinations including specialty examinations as indicated for medically indigent children, with particular attention to those children who are candidates for classes in special education (mentally retarded, physically handicapped, etc.)

Continued support to grade and high school programs in physical education, driver training, vision and hearing screening, immunizations and tuberculin testings, school bus safety, and stimulation of student interest in medical and paramedical careers.

Cooperation with the Disaster Medical Care Committee by appointment of a member of our committee to establish liaison with its Chairman for the purpose of conveying the interest of the School Child Health Committee in its program.

REFERENCE COMMITTEE RECOMMENDATION—The report was approved and commended. It is recommended that the postgraduate courses in medical aspects of sports for coaches, physicians, trainers and educators be continued on a yearly basis.

HOUSE OF DELEGATES ACTION—Adopted the report of the School Child Health Sub-Committee as recommended by the Reference Committee on motion duly made and seconded.

Rehabilitation Sub-Committee

ROBERT L. BENNETT, M.D., *Chairman*

The Sub-Committee on Rehabilitation has continued its efforts to stimulate and coordinate interests and activities in rehabilitation. It was called upon to discuss only two questions this past year.

1. Consideration of approval of the rehabilitation center now being developed under the Division of Vocational Rehabilitation of the Georgia State Department of Education. This vocational center for handicapped individuals is being built on a 13-acre site immediately adjacent to the Georgia Warm Springs Foundation. This was approved by the Sub-Committee.
2. Physical Therapy Legislation: The Physical Therapy Practice Act of 1951 empowered the State Board of Medical Examiners to register physical therapists by examination, reciprocity, or other conditions set forth in the Act. The physical therapists, through House Bill No. 895, desired a new Act which would create a separate Board of Physical Therapy not under the State Board of Medical Examiners, empowered to license rather than register the physical therapists. The Sub-Committee did not approve of a separate Board without medical representation.

The Legislature eventually saw fit to amend the Physical Therapy Practice Act of 1951 and created a Board of Physical Therapy without medical representation, but otherwise continuing the registration as previously enacted.

REFERENCE COMMITTEE RECOMMENDATION—The report was approved and commended with particular commendation to Dr. Bennett for his intensive interest and participation in the affairs of the Sub-Committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the Rehabilitation Sub-Committee as recommended by the Reference Committee on motion duly made and seconded.

Crippled Children Sub-Committee

E. B. DUNLAP, JR., M.D., *Chairman*

As Chairman of the Sub-Committee on Crippled Children, I should like to advise you that there has been no called meeting of this committee nor activity to be reported in the Annual Report to the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION—The report of this Sub-Committee was accepted and the work of its Chairman was commended and approved.

HOUSE OF DELEGATES ACTION—Adopted the report of the Crippled Children Sub-Committee as recommended by the Reference Committee on motion duly made and seconded.

Resolution No. 4

CHEMICAL AND BIOLOGICAL WARFARE WEAPONS

SPALDING COUNTY MEDICAL SOCIETY

Whereas, The Medical Association of Georgia has logical reason to believe that great advances have recently been made in the area of Chemical-Biological warfare and

Whereas, it must be assumed that potential enemies of this country possess the same capabilities and

Whereas, American physicians have had little opportunity to familiarize themselves with medical defense against newer Chemical-Biological weapons because of the classified status of these weapons

Therefore, be it resolved that the American Medical Association approach the Department of Defense in an effort to determine means of improving physician's ability to care for casualties of Chemical-Biological warfare or accidental exposure of the population to such weapons.

REFERENCE COMMITTEE RECOMMENDATION—The Reference Committee approves Resolution No. 4; Chemical and Biological Warfare Weapons, and recommends that it be implemented by the Association.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 4: Chemical and Biological Warfare Weapons, as recommended by the Reference Committee on motion duly made and seconded.

Resolution No. 7

CREATE STUDY COMMITTEE ON GEORGIA ADOPTION PRACTICES

J. W. VEATCH, JR., DELEGATE, FULTON COUNTY MEDICAL SOCIETY

Whereas, the physicians of this state have always been interested in the mental and physical health of the children of this state, and

Whereas, many special problems arise when, of necessity, a child has to be separated from his natural parents such as in adoption, and

Whereas, adoption involves the three disciplines of law, medicine, and social services, and

Whereas, physicians are invariably associated in adoption practices both in work with the natural parents, the adoptive parents, and the children,

Be it resolved that the Medical Association of Georgia appoint a committee to study the adoption practices in this state and bring back to this group recommendations regarding the proper role of the physician in the adoption process and the relative responsibility of physicians in relation to the legal and social service groups.

REFERENCE COMMITTEE RECOMMENDATION—Resolution No. 7 To Create a Study Committee on Georgia Adoption Practices. The Reference Committee approves the Resolution and requests that this Committee be set up as a special Committee of MAG.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 7: To Create a Study Committee on Georgia Adoption Practices, as recommended by the Reference Committee on motion duly made and seconded.

It was moved by the Chairman of the Reference Committee No. 2, A. J. Waters, Augusta and duly seconded that the report of Reference Committee No. 2 be approved as a whole and it was so ordered.

Report of Reference Committee No. 3

Reid Gullatt, M.D., Chairman

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 3 met at 8:00 A.M. in the Red Surrey Lounge, DeSoto Hotel, May 7, 1962. Members present were: Reid Gullatt, Cochran, Chairman; T. A. Sappington, Thomaston, Vice Chairman; J. H. Hilsman, Atlanta, Secretary; M. L. Johnson, Jr., Bowdon; C. P. Lampros, Clayton; C. R. Williams, Wadley; L. O. J. Manganiello, Augusta; and F. V. Kay, Macon.

AMA Delegates

HENRY H. TIFT, M.D., Macon, Chairman

EUSTACE A. ALLEN, M.D., Atlanta

J. W. CHAMBERS, M.D., LaGrange

The 1961 Annual Session of the American Medical Association was held in New York City June 26th through June 30th. All three of the Georgia Delegates attended all sessions of the House of Delegates. In addition, Dr. Carter Smith, newly elected Delegate representing the Section of Internal Medicine, joined our group. Dr. Tift served on the Reference Committee on Insurance and Medical Service. For the first time in many years, Georgia had a hospitality suite, with Georgia doctors and their wives as hosts and hostesses. Visitors from many states were welcomed. The highlight of the session, from our standpoint, was the

election of Eustace A. Allen to the office of Vice President of the AMA. He was nominated by J. W. Chambers, the nomination was seconded by Delegates from numerous states, and the vote was unanimous. Our Delegation introduced two resolutions: "Opposition to Compulsory Social Security Coverage for Self-Employed Physicians," and "AMA Policy Support." Both resolutions were adopted by the House.

The 1961 Clinical Session of the AMA was held in Denver, Colorado, November 26th to 30th. Our Delegates again attended all meetings of the House except for the last session, which Dr. Chambers had to miss because of an emergency. His place was taken by George Dillinger, Alternate Delegate. Dr. Chambers served on the Reference Committee on Medical Military Affairs.

In recent years the Georgia Delegation has had a breakfast meeting the day after the opening session of the House of Delegates. At this meeting we go over all of the resolutions and reports that will be discussed at Reference Committees and we request various members of our group to attend specific committee meetings to give our views and to bring back reports. Our meeting in Denver was attended by several AMA personalities, including Dr. Ernest B. Howard, Assistant Executive Vice President, Dr. Roy Lester, of the Washington office, Mr. Aubrey Gates, Director of Field Services, Mr. Richard Nelson, Field Representative of our area, and Reverend Paul McCleave, new Director of Religious Activities.

We wish to acknowledge the great help given our Delegation by members of the Staff and Officers of the Medical Association of Georgia and by other members of the Association who volunteered their services. Because of their assistance, we feel that Georgia was well represented at all important Committee meetings.

We urge all MAG members to attend at least one Annual Session or Clinical Session of the AMA. We also urge all MAG members to join the American Medical Association. To those MAG members who have doubts as to the value of the AMA membership, we would welcome an opportunity to discuss its services and policies with you, either personally or before your County Society.

Alternate Delegate

GEORGE R. DILLINGER, M.D., Thomasville

During the past year your alternate delegate attended both the New York Annual Session and the Denver Clinical Session in November. At the Denver Clinical Session your alternate served as Delegate during the final session in the absence of the regular Delegate. The work of the delegation is handicapped by the lack of attendance of the other alternates. The various reference committee activities need coverage by the Georgia Delegation.

It is imperative that men interested in the activities of the medical profession be elected to this office.

REFERENCE COMMITTEE RECOMMENDATION—The report of the AMA Delegates is accepted in its entirety and the Reference Committee commends the Delegates for their fine work. It is felt by this Reference Committee that a more realistic approach to the expenses that have been incurred by both the Delegates and the Alternate Delegates be considered by the MAG Council, as the Reference Committee feels that the expenses of both the Delegates and the Alternate Delegates should be met.

Council of MAG

GEORGE H. ALEXANDER, M.D., *Chairman*

Mr. Speaker and members of the House of Delegates:

The year 1961-62 has been a year notable for many activities and important events; I am sure one of the busiest in the history of the Association.

The Councilors, Vice-Councilors and other members of Council and the Executive Committee have manifested great interest and worked enthusiastically and harmoniously.

I want to express my thanks to the members of Council for their excellent attendance, diligence and courtesy.

At the Organizational Meeting of Council on May 10, 1961, George H. Alexander, Forsyth, was elected Chairman with Virgil Williams, Griffin, being elected Vice Chairman. Edgar Woody, Jr., of Atlanta was reappointed as Editor of the JMAG. J. G. McDaniel, Atlanta, was named Chairman of the Finance Committee. C. Raymond Arp, Atlanta, was reappointed as Treasurer. Mr. Milton D. Krueger was reappointed Executive Secretary.

During the year 1961-62, MAG operated for the first year with the enlarged Council as finally approved at the 1960 annual session. This transition took place smoothly and the new system has worked well.

The new organizational plan of Association Boards and Sub-Committees also was implemented and has worked well and with a short additional period during which some minor changes might be advisable should be a tremendous improvement. A member of Council serves on each Board and this makes for good liaison with and responsibility to Council.

Perhaps if any single event deserves special mention it should be the implementation of the Kerr-Mills Program of Medical Aid to the Aged (MAA) in which MAG entered into a contract with the Welfare Department agreeing to furnish advisory services in the implementation and in claim processing. Dr. John Mauldin is employed by MAG as Medical Director. This program has gotten off to a good start and is rendering much needed help to the State's indigent aged.

It is impractical in this report to enumerate all of the questions taken up and handled by Council and the Executive Committee, the details of which can be found in the minutes of Council and the Executive Committee as published in the JMAG. However, it is well to enumerate some of the more important matters in addition to those mentioned above:

- (1) Appointment of Board and Sub-Committee members to implement new organizational plan.
- (2) Elected not to participate in AMA-GP of year award. (This award has since been discontinued by AMA.)
- (3) Became stockholder (\$200.00) in State Medical Journal's Advertising Bureau.
- (4) Voted to make available to all candidates for State offices the MAG Health and Medical Care Policies.

- (5) Named J. G. McDaniel as temporary Acting Treasurer following the unfortunate and untimely death of C. Raymond Arp. John S. Atwater later named to serve unexpired term.
- (6) Authorized revision of MAG Charter to better identify MAG as a charitable, educational, eleemosynary corporation related to the Science of Medicine for the benefit of the general public.
- (7) Studied proposed recodification of Health Laws, approving same after elimination of certain objectionable features. (Failed to pass in Legislature.)
- (8) Passed resolution endorsing and supporting AMA Department of Medicine and Religion.
- (9) Asked Legislative Board to study possibility of introducing law regarding Ethical and Legal Conduct of Doctors of Medicine.
- (10) Approved recommendation of Relative Value Study Committee that values of California Medical Association be adopted. Also approved coefficients as recommended for use in insurance plan for State Merit System workers.
- (11) Approved revision for method used in selection of recipients of MAG awards. The Hardman Award is the one primarily affected by this revision.
- (12) Brief, as friend of the Court, filed in Meriwether-Harris County hospital problem with final action — favorable to the Hospital Board and Medical Staff. This was an important and far reaching decision in that it upheld the authority of hospital boards to make appointments and to revoke appointments to the Medical Staff upon recommendations of the hospital medical staff.

At the March 17-18 Meeting of Council there were some additional important items referred to the House of Delegates:

- (1) Council voted to refer to the House of Delegates a resolution addressed to Governor and Mrs. Vandiver commending them for their activity in the field of mental health and the program of constructing chapels for mental patients with the recommendation to the House of Delegates that this resolution of commendation be passed by the House.
- (2) On motion (Walker-McDaniel) it was voted that Council take no action on the AMA Blue Shield aged care plan but that this matter be referred to the House of Delegates by means of the majority report of the Board of Insurance and Economics with minority report to be filed by Charles Jones. It was further voted to request that the majority report include any additional data favorable to the plan which might be gathered prior to the annual session, and that the minority report of Dr. Jones include any available data unfavorable to the plan.
- (3) Council had received a questionnaire from the South Dakota State Medical Association regarding the problem of AMA assuming original jurisdiction in matters of medical discipline

where the local Society and State Association had failed to do so. Council voted to go on record as opposing original jurisdiction by the AMA but did vote in favor of an information clearing house being set up by AMA where information concerning Doctors of Medicine moving from one area to another could be supplied to local County societies on request.

- (4) In the legislative report, Dr. Walker reported upon his investigation concerning the possible introduction of a bill into the Legislature providing for a Board of Medical Discipline to be set up to handle disciplinary problems which might arise involving the ethical and legal conduct of Doctors of Medicine. Council voted to refer to the House of Delegates with Council approval of the proposal to introduce such a bill providing for such a board to be patterned after the bill which is now operating in the State of Washington.

This report would be derelict without special recognition and appreciation for the contributions of certain "key individuals."

Fred Simonton, Chickamauga, our Association President, with his numerous contacts and "know-how" has done an outstanding job during this eventful year. The Association owes its appreciation to the Vice Presidents who have served well during the past year; Linton Bishop being due a particular commendation for his valuable assistance in the matter of relations with the City of Atlanta and Fulton County officials. Milford Hatcher, Macon, as Immediate Past President, has continued the fine type of work characteristic of him while he was President. Thomas W. Goodwin, Augusta, the President-Elect, with his level head and wise counsel has been invaluable. John T. Mauldin, Atlanta, the Association Secretary, has continued his untiring and valuable efforts for the Association; without him, the difficult job of getting the Kerr-Mills program "off the ground" would have been even more difficult. He deserves our support and thanks for his efforts in this program in particular and for all his other contributions.

Council was truly saddened by the untimely death of Treasurer C. Raymond Arp in October. He is remembered with appreciation. His successors, J. G. McDaniel

and finally John S. Atwater have done a fine job as Treasurer. A special word of appreciation is due our Finance Committee, headed by J. G. McDaniel of Atlanta, for preparation of the Annual Association Budget and its presentation to Council. Edgar Woody, Jr., Atlanta, as Editor of the *Journal of the Medical Association of Georgia*, has continued his outstanding work in producing an excellent Journal which is a credit to him and MAG. Virgil Williams, Griffin, as Vice Chairman, deserves commendation and thanks.

Mr. Milton D. Krueger, our Executive Secretary, has continued to serve in the outstanding manner which is characteristic of him — putting in long hours dedicated to the interests of MAG. Mr. James M. Moffett continues his excellent work as Assistant Executive Secretary. He has been of particular service in legislative matters. Mrs. Catherine Wooten, as Executive Assistant, has continued to be a most valuable addition to the staff. Miss Thelma Franklin is due thanks for her continued fine work and loyalty as have the other secretarial and clerical assistants. Mr. Franz Lipsey has continued to do a capable and efficient job as Medicare Administrator. Our appreciation is deserved by all of these folks at Headquarters.

The Finance Committee report and the reports of individual Councilors and Vice-Councilors follow.

The reports of the Association Boards and Committees are not being included as a part of Council Report. They are being made separately and will be considered separately by the designated reference committees.

REFERENCE COMMITTEE RECOMMENDATION—The report by the Council of the MAG is approved as printed in the Delegates Handbook.

HOUSE OF DELEGATES ACTION—Adopted the report of the Council of MAG as recommended by the Reference Committee on motion duly made and seconded.

Finance

J. G. MCDANIEL, M.D., *Chairman*

The following budget for the operating year 1962 was approved by Council. Prior to presenting this budget to the Council, the Association Committee on Finance reviewed each request for funds made by Board, Committee and Sub-Committee Chairmen.

		1961 Budget	Actual Jan. 1—11/30/61	1962 Budget
INCOME				
I.	(a) MAG Dues	\$100,680.00	\$102,140.00	\$102,000.00
	(b) Int. and AMA	800.00	1,438.51	1,200.00
	(c) GP Service	2,820.00	2,585.00	3,250.00
	(d) Funds Carr. 1960	9,720.24	9,720.24	—
II.	(a) Annual Session	\$ 9,625.00	\$ 9,800.00	\$ 8,225.00
III.	Journal	\$ 50,000.00	\$ 32,164.36	\$ 38,000.00
	Total Income	\$173,645.24	\$157,848.11	\$152,675.00
EXPENSES				
I.	(a) Fixed Allot.	\$ 14,300.00	\$ 6,559.29	\$ 13,450.00
	(b) Assoc. Office	68,073.00	54,841.47	68,450.89
	(c) Assoc. Boards	22,065.00	16,892.40	20,745.00
	(d) Rel. MAG Act.	2,950.00	1,948.61	1,400.00
	(e) Cont. Fund	14,123.99	7,554.49	4,077.91
II.	Journal	\$ 52,133.25	\$ 38,114.96	\$ 44,551.20
	Total Expenses	\$173,645.24	\$125,911.22	\$152,675.00

I. (a) FIXED ALLOTMENTS

Payment on Mort.	\$ 4,000.00	\$ —	\$ 4,000.00
Int. on Mort.	2,000.00	—	1,350.00
MAG Atty. Exp.			
Retainer	2,400.00	1,800.00	2,400.00
Expenses	500.00	109.29	300.00
Woman's Aux.	1,500.00	1,500.00	1,500.00
Pension Payments	2,400.00	1,650.00	2,400.00
Pres. Honarium	1,000.00	1,000.00	1,000.00
Annual Audit	500.00	500.00	500.00
(A) Sub-Total	\$ 14,300.00	\$ 6,559.29	\$ 13,450.00

(b) ASSOCIATION OFFICE

Salaries	\$ 37,675.00	\$ 33,903.97	\$ 38,920.00
Bonus	1,787.50	—	1,925.41
Ins. and Bond	1,100.00	897.40	1,000.00
Payroll Taxes	2,260.50	1,180.40	1,705.48
Travel:			
Office	4,000.00	3,369.78	4,000.00
Del. Sec. to AMA			
Annual and Clinic	2,000.00	1,750.00	2,000.00
Main. and Repair:			
Building	2,500.00	272.40	750.00
Equipment	750.00	471.05	750.00
Tel. & Tel.	4,200.00	3,850.07	4,000.00
Depreciation:			
Building	2,400.00	—	2,000.00
Equipment	1,200.00	—	650.00
Postage	3,000.00	2,262.87	3,000.00
Office Supplies	2,500.00	2,555.65	2,750.00
Jan. Serv. and Grat.	1,300.00	1,169.00	1,450.00
Meetings	750.00	732.60	800.00
Dues and Sub.	200.00	224.00	250.00
Heat, Light and Water	2,100.00	1,857.22	2,100.00
Sundry	350.00	345.06	400.00
Sub-Total	\$ 70,073.00	\$ 54,841.47	\$ 68,450.89

(c) ASSOCIATION BOARDS

	1961 Budget	Actual Jan. 1—11/30/61	1962 Budget
1. Annual Session	\$ 10,215.00	\$ 10,387.00	\$ 8,525.00
2. Constitution and Bylaws	—	—	—
3. Hospital Activities	—	—	—
A. Blood Banks	—	—	100.00
B. Hospital Rel.	600.00	157.35	50.00
4. Governmental Med. Sev.	—	—	100.00
A. Crippled Child.	—	—	—
B. Dis. Med. Care	150.00	57.48	200.00
C. Mat. and Inf. Wel.	200.00	173.49	305.00
D. Pub. Hlt.	—	—	100.00
E. Rehabilitation	—	—	—
F. Sch. Cld. Hlt.	1,900.00	1,174.42	1,650.00
G. Vet. Affairs	50.00	—	150.00
5. Ins. and Econs.	500.00	368.60	900.00
A. Rel. Val. Sdy.	—	—	840.00
6. Interprof. Rel.	200.00	86.74	125.00
7. Legilsation	2,000.00*	2,000.00*	2,500.00
A. Nat. Leg.	—	—	—
B. State Leg.	—	—	—
8. Med. Education	—	—	—
A. AMEF	—	—	—
B. Clks. Labs.	—	—	—
C. Med. Ed.	100.00	100.00	200.00
D. Med. Sch. C.	100.00	76.72	—

9. <i>Occup. Health</i>	—	—	400.00
A. Ind. Hlt.	300.00	292.12	—
B. Rul. Hlt.	200.00	—	100.00
10. <i>Public Service</i>	2,000.00	171.34	1,800.00
A. Public Ser.	—	—	—
B. Wky. Hlt. Clm.	1,900.00	1,299.01	2,000.00
11. <i>Special Act.</i>	—	—	—
A. Hlt. Care Ag.	1,400.00	395.94	400.00
12. <i>Vol. Hlt. Agencies</i>	—	—	—
A. Cancer	—	—	300.00
B. Mental Hlt.	250.00	152.19	—
(c) Assoc. Bds. Tot.	\$ 22,065.00	\$ 16,892.40	\$ 20,745.00

(d) REL. MAG ACTIVITIES

AMA Del. Meet.	\$ 500.00	\$ 436.50	\$ 400.00
C.W. Long	500.00	500.00	—
Med. Defense	1,000.00	100.00	300.00
Phy-Law Liaison	300.00	356.59	50.00
Prof. Conduct	50.00	—	50.00
SAMA	500.00	469.00	500.00
SMEB	100.00	86.52	100.00
(D) Sub-Total	\$ 2,950.00	\$ 1,948.61	\$ 1,400.00

(e) CONTINGENT FUND

1961 Cont.	\$ 4,403.75	—	—
1960 Unapp.	1,115.45	—	—
1960 Spec. Meet.	1,654.79	\$ 1,654.79	—
1960 Pay. on Mtg.	5,000.00	5,000.00	—
State Med. Adv. Bur.	200.00	200.00	—
1960 Legislation	800.00	249.70	—
1960 AMA Del. Mt.	500.00	—	—
1960 Atty. Welf. Contr.	450.00	450.00	—
	\$ 14,123.99	\$ 7,554.49	—

II. JOURNAL	1961 Budget	Actual Jan. 1—11/30/61	1962 Budget
Expenses:			
Printing	\$ 40,000.00	\$ 27,208.28	\$ 32,000.00
Salaries	5,700.00	5,677.82	5,760.00
Bonus	662.50	—	585.00
Ins. & Bond	189.00	102.15	136.20
Payroll Taxes	381.75	278.40	350.00
Engr. & Cuts	1,800.00	2,339.75	2,400.00
Sales Tax	1,200.00	821.05	960.00
Postage	500.00	500.00	500.00
Stationery	500.00	501.77	500.00
Clipping Ser.	350.00	289.39	250.00
Add. & Sup.	250.00	217.18	250.00
Editorial Asst.	250.00	100.00	250.00
Meetings	300.00	—	550.00
Sundry	50.00	79.17	60.00
TOTAL	\$ 52,133.25	\$ 38,114.96	\$ 44,551.20

3/25/61 Council approved Legal Assistance to Meriwether-Harris County Medical Society. Possibly as much as \$6,000.00.

(*See Contingent Fund)

REFERENCE COMMITTEE RECOMMENDATION—The report of the Finance Committee is approved and the Committee wants to highly commend the Chairman and his Committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the Finance Committee as recommended by the Reference Committee on motion duly made and seconded.

Professional Conduct Committee

WILLIAM P. HARBIN, M.D., *Chairman*

During the past year, the Professional Conduct Committee has been requested to advise with and give opinions to two members of the Medical Association of Georgia on matters regarding ethics. Recently the Executive Committee has requested that the Professional Conduct Committee make recommendations regarding certain matters having to do with the licensure of osteopathic hospitals and it is expected that such recommendations will be made prior to the meeting of the House of Delegates at the annual session.

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves the report of the Professional Conduct Committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the Professional Conduct Committee as recommended by the Reference Committee on motion duly made and seconded.

Woman's Auxiliary Advisory

LUTHER H. WOLFF, M.D., *Chairman*

The Advisory Committee to the Woman's Auxiliary of the Medical Association of Georgia met formally with the Executive Board of the Woman's Auxiliary at their annual conference. This conference was held at the MAG Headquarters Building on July 19, 1961.

At this conference, under the able direction of the Auxiliary President, Mrs. A. Worth Hobby, detailed plans for the coming year were presented by the various Committee Chairmen. These plans were discussed fully and completely. The Advisory Committee was tremendously impressed with the magnitude and thoroughness of the planning evidenced at this meeting, and approved wholeheartedly all aspects of the proposed program.

During the past year the Auxiliary has functioned smoothly and efficiently, and has done a great deal to implement the basic programs of the Medical Association of Georgia.

The Advisory Committee wishes, on behalf of the Medical Association of Georgia to commend and congratulate the officers, committee chairmen, the county society officers, and the members of the Woman's Auxiliary for their splendid work and cooperation of the past year.

REFERENCE COMMITTEE RECOMMENDATION—This report is accepted and approved and the Committee commends the Chairman and his members for their fine work.

HOUSE OF DELEGATES ACTION—Adopted the report of the Woman's Auxiliary Advisory Committee as recommended by the Reference Committee on motion duly made and seconded.

Insurance and Economics

DAVID R. THOMAS, JR., M.D., *Chairman*

The work of the Board during the year has been primarily concerned with the economics affecting the profession and the insurance for the members and insurance coverage for the public. The liaison with the insurance industry, directly, and through the Health Insurance Council has been very satisfactory. Close liaison with the Headquarters Staff and legal council is

acknowledged and is very necessary for the proper function of the Board and its sub-committees.

The Georgia Plan

The Georgia plan was established when conditions were much the same as they are today concerning the socialization of medicine. It was thought by many of us that this served a very useful purpose at that time and continues as a means of offering medical coverage on a service basis. Dr. John Elliott and Mr. H. B. Colledge of Savannah have very faithfully continued to act as arbitrators in handling the claims where there are differences with the participating insurance carriers. The participation is not as great as formerly but the basic principle remains the same and it is felt that this should be continued.

Continuing of Insurance Coverage for Retiring Employees

Most employers are still covering their employees with hospitalization insurance and other medical benefits only until the time of their retirement. It is felt that continued work and attention should be given to the provision of insurance coverage after retirement.

Senior Citizens Insurance AMA-Blue Shield

Though we have followed and advocated for several years, insurance programs that would offer a realistic hospitalization and medical care coverage for senior citizens (ages 65 and above) there has been very little offered by the insurance industry or Blue Cross-Blue Shield, except by group contracts.

In February the AMA precipitously announced that the National Blue Shield group would offer this coverage to those 65 and over. The cooperation by physicians in the fifty states is being solicited in offering this coverage on a service contract to individuals with an over-all annual income of not more than \$2,500.00, and to married couples with an over-all annual income of not more than \$4,000.00. This insurance would be offered to other senior citizens on an indemnity basis.

At the meeting of the Board, March 11th, it was recommended to the Council of MAG that this be adopted in principle. This Board, through a sub-committee, would be responsible for establishing a working arrangements to consummate this program.

The urgency of this matter seems to rest with the socialistic reforms, as unrealistic as they are, that are being sponsored by certain elements of the Federal Government. The Committee feels that this is an urgent obligation of the profession in taking the offensive to help defeat undesirable socialistic legislation.

Though there was one dissenting vote to the motion that the Medical Association of Georgia endorse, in principle, the Senior Citizen contract as offered by National Blue Shield plan, the Board feels that the question raised, of comparison with other available insurance, is not pertinent to the question. The request from the American Medical Association Board of Trustees. *Res Ipsa Loquitur*, properly applies in this case. At this time this support of organized medicine is requested to combat the present socialistic trend and the socialistic legislation being considered in Congress. It is felt that if the Medical Association of Georgia cannot support, in principle, the plan of making available adequate insurance coverage for the Senior Citizens of a limited income group, who have always been able to

care for themselves, we would but further add just condemnation from those who are supporting the King-Anderson Bills.

Relative-Value Schedules

The Committee for the study of the Relative-Value Schedules was established and is headed by Dr. Harry D. Pinson, who will give a detailed report.

Retirement Program

There were only 754, or 30%, usable replies received in answer to the questionnaire, concerning the income of members of MAG, sent out in the Spring of 1961. This information was presented to the American Medical Association for their advice; this was received by them for information only. It is felt that further study is needed and the establishment of some means of making available to members of the profession, as much relief as possible from the ever-increasing tax burden. The present legislation in HR-10 (pending in the U.S. Senate) offers help to some extent.

MAG Group Plans

The participation in the insurance plans as offered through the Life Insurance Company of Georgia, is participated in by only approximately one-third of our members. As a result of the poor participation the premium was increased on the Major Hospital coverage, November 15, 1961. The over-all loss ratio of the Life Insurance Company of Georgia, as experienced by them, was 111.7% of the earned premium on all types of coverage. The loss ratio on Major Hospital is 140%.

It is felt that coverage offered our members in their policies is in many ways better than that offered by the other group policies available through specialty organizations, and that support of this program with greater participation, is essential if we are to have dividends, either through reduced premiums or increased coverage. Future studies are being conducted and every effort is being made to improve this coverage. It is basic to the plan that we want good coverage with maximum protection for the premium paid. The full consideration of the members of MAG is urgently solicited.

Minority Report, Insurance and Economics Board

CHARLES S. JONES, M.D., *Atlanta*

Introduction

At the direction of the MAG Council in its March 17th and 18th meeting I am writing a minority report of the Insurance and Economics Board on the matter of MAG approval and adoption of the Blue Cross-Blue Shield National Senior Citizens Program. It is the purpose of this report to point out why the doctors of Georgia should not approve this program. Briefly it is designed to provide semi-private hospitalization for up to seventy days together with surgical and some medical services on a fixed fee basis. Those eligible will be 65 years of age or over with an annual income per couple up to \$4,000. The premium will be about \$365.00 annually: One-fifth of this for professional fees and four-fifths for hospitalization.

This program which is to be nationally administered from a centralized office of Blue Shield, has the endorsement of the AMA. It is an alternate which some think might prevent passage of the King-Anderson bill.

At the outset it seems superfluous to mention that the

medical profession will continue in the future as in the past to render any necessary services to any needy patient free of charge or for any reduced fee that might fit the circumstances of the case. By our deeds, much more than our words, we have always met this need.

Indemnity vs. Service Contracts

In the field of casualty insurance risk is figured on the basis of extent of liability and the frequency of occurrence of liability. The premium is that amount of money which will cover this risk and provide the necessary operating profit. Casualty insurance is written on an indemnity basis. In this contract the insurance company agrees to pay the policyholder up to a specified amount of money in the event of loss as defined in the policy. By this means the insurance company knows the extent of its financial commitment and can operate on a sound basis. In health insurance, a type of casualty insurance, the company is responsible to the policyholder. The doctor has no part in the contract, which is as it should be. He is solely responsible to his patient.

On the other hand a full service contract is one in which the repairman, in our case the doctor, agrees in advance, to accept a fixed fee for a loss which has not yet occurred and the precise extent of which is not known. The insurance company has a known liability exactly as exists in an indemnity contract; the patient has an established premium. The doctor, and he alone, takes the chance. For any unusual circumstances he must bear the loss. The doctor will become an addendum on an insurance policy and his services will be sold by the insurance salesman. We should never forget that our obligation is to our patient not to any insurance company. In return the patient should have an obligation to us. When a third party is injected into this arrangement and he controls the purse strings, he will also control other aspects of the relationship.

The insurance industry has done an outstanding job in the health field. Over 135,000,000 Americans now have health insurance. With the exceptions of some local programs it is all on an indemnity basis. It is actuarially sound, very sound. There is no need for the medical profession to succumb to third party control in order to improve the salability of this type of insurance.

In a full service contract for health insurance there is one feature which is actuarially unsound. This is the risk which the participating physician is asked to take, and the control to which he must submit.

The Fee Schedule vs. Principles

Having been a member of the Insurance and Economics Board for nearly 10 years I have heard many and long discussions of fee schedules. The best and quickest way I know to get any group of doctors into a zone of impossible disagreement is to attempt to standardize fees. The reason for this is simple. No one is qualified to determine the proper fee for any medical service but the doctor who renders the service working with the patient who receives it. Any effort to determine in advance what should be the charge for treating a disease is impractical and unworkable. No one has yet figured out how to determine the cost of repairing a damaged automobile before it is damaged, and this should be a much simpler matter.

In a service contract the participating physician signs a submissive agreement. Not only does he agree to accept fixed fees, but he also sacrifices other prerogatives. Any extra payment for unusual services is

decided by the company, not the doctor. Future negotiations occur only when the company is willing; grievance procedures are decided solely by the company without further recourse. Such features as no consultation fee, no provisions for intensive care, and payment for only one visit daily would have a definite tendency to influence the type of medicine practiced.

Before doctors become involved in this National Blue Shield Program they should carefully consider the principles of individual initiative which would be compromised. Fee schedules should be relegated to a matter of secondary importance. Don't become so divided discussing fees that you lose sight of more important principles sacrificed in this submissive agreement.

National vs. Local Control

The Blue Shield National Senior Citizens Program has been discussed at length by the Insurance and Economics Board and by the Council of MAG. Those who have favored acceptance of this program, for the most part, live in sections of our state covered by the Columbus Blue Cross-Blue Shield. It is my understanding that this plan has service contracts for certain economic groups. Recently these have been working with satisfaction, at least to the surgeons. It should be clearly understood that these plans are administered locally by a democratically constituted board. I further understand that a doctor is not bound by the contract if he feels that a patient is over the specified income limit. The burden of proof is with the patient.

This is an entirely different situation from that which would exist in a national program administered centrally in some distant city. For example the question of eligibility was specifically asked of a National Blue Shield representative by the Board. He stated that any patient who signs the contract must be accepted by the participating physician regardless of additional information which the doctor might have. I can well imagine the difficulties which a doctor might have convincing the National Blue Shield office that a given patient in Georgia was over the specified income limit. Any deviation from the letter of the contract would be most difficult to obtain. The program itself could offer many more complications than it solved problems.

The King-Anderson Bill

This bill provides for hospitalization and nursing care for the over 65 year group within the tax structure of Social Security. It does not provide for medical fees.

Organized medicine has been a bulwark of opposition to this bill. We are now told that we can further oppose this bill by submitting to a National Blue Shield Program. I sincerely question the wisdom of such a move.

To the politician in Washington submission by the medical profession to this program could suggest tacit acceptance of the principle of the King-Anderson bill. This might actually foster the passage of the bill rather than oppose it.

Conclusions

Let us not mix political expediency with basic principles. I recommend to the House of Delegates that the Medical Association of Georgia decline to endorse the National Blue Shield Program on a full service basis. It is further recommended that the Medical Association of Georgia endorse the principle of assistance to our

needy senior citizens, and that we urge Blue Shield to foster their program on an indemnity basis.

REFERENCE COMMITTEE RECOMMENDATION—After considerable discussion with many interesting comments both pro and con, both majority and minority reports have been considered in detail by this Committee. It is felt by this Committee that adequate health coverage for senior citizens is certainly highly important. It is felt that the principle of the majority report should be accepted even in the face of the excellent comments of the minority report. It is also felt by this Committee that acceptance of the majority report should be made with a definite provision that the National Blue Shield Senior Citizens Program will be administered and controlled only on a local basis by the local Blue Shield Plan.

HOUSE OF DELEGATE ACTION—Speaker Walker called for a discussion of the Reference Committee recommendation. He recognized J. H. Harrison of Fulton County, who spoke against adoption of the Reference Committee recommendation. Speaker Walker also recognized Tully T. Blalock, Fulton County, who discussed the report and spoke against adoption of the Reference Committee recommendation. Reference Committee No. 3 Chairman Reid Gullatt was recognized by Speaker Walker and spoke in favor of the Reference Committee recommendation. Linton Bishop, Fulton County, was recognized by Speaker Walker and spoke against adoption of the Reference Committee report. Speaker Walker recognized Thomas Anderson of Fulton County Medical Society, who spoke against the adoption of the Reference Committee report. David R. Thomas, Jr., Chairman of the Insurance and Economics Board, was recognized by Dr. Walker and spoke for the adoption of the Reference Committee recommendation. William Moore, Fulton County Medical Society, discussed the Reference Committee recommendation and spoke against its adoption after being recognized by Speaker Walker.

On motion (William Moore-Henry Jennings) it was moved to table this portion of the Reference Committee recommendation. Speaker Walker ruled that a motion to table cannot be discussed and called for a vote on this motion. The vote as tabulated was 52 votes in favor of the motion and 31 votes against the motion. Speaker Walker ruled that the motion carried and that the Reference Committee recommendation on that portion of their report concerning the Insurance and Economics Board and the Reference Committee recommendation on the National Blue Shield Senior Citizens Program be tabled.

Resolution No. 9

INDEMNITY BASIS HEALTH CARE PLANS

WILLIAM MOORE, DELEGATE, FULTON COUNTY
MEDICAL SOCIETY

Therefore, be it resolved that the Medical Association of Georgia only consider for approval such voluntary health care programs and/or fee schedules as are on an indemnity basis.

REFERENCE COMMITTEE RECOMMENDATION—It is felt by this Committee that Resolution No. 9: Indemnity Basis Health Care Plans, is disapproved due to the Committee's previous approval of the majority report of the Insurance and Economics Committee.

HOUSE OF DELEGATES ACTION—A point of order was raised by William Moore, Fulton County Medical Society, concerning Resolution No. 9: Indemnity Basis Health Care Plans. He stated the Reference Committee recommendation on this Resolution makes reference to a previous recommendation on the Insurance and Economics Board report which was tabled. Dr. Moore spoke against the Reference Committee recommendation on Resolution No. 9. William Coles, Fulton County Medical Society, spoke for the Reference Committee recommendation on Resolution No. 9.

At this time, Speaker Walker recognized William Moore who proposed the following amendment to Resolution No. 9 to add: "only in the future" to the end of the Resolution making it read as follows: "Therefore, be it resolved that the Medical Association of Georgia only consider for approval such voluntary health care programs and/or fee schedules as are on an indemnity basis only in the future." This amendment from the floor was accepted by the author of Resolution No. 9 and the Reference

Committee Chairmen. At this time, there being no further discussion, the question was called and a vote was taken on the Reference Committee recommendation on Resolution No. 9. The vote as recorded was 44 for the Reference Committee recommendation on Resolution No. 9 (as amended) and 41 against the Reference Committee recommendation on Resolution No. 9 (as amended).

Speaker Walker then ruled that the Reference Committee recommendation in disapproving Resolution No. 9 was upheld by such vote, thereby foiling to enact or approve Resolution No. 9 (as amended).

Relative Value Study Sub-Committee

HARRY D. PINSON, M.D., *Chairman*

During the year 1961-62, the Relative Value Study Committee held three meetings and as Chairman, I attended a Workshop on Relative Value Studies in Kansas City, Missouri held by the Professional Services Committee of the American Medical Association in September, 1961. At our last meeting in November, 1961, we voted to recommend adoption of the California Relative Value Schedule as amended in 1960 and to be amended as indicated after further study.

At the request of the State of Georgia Personnel Board, we furnished them recommendations for their proposed insurance coverage for state employees based on the Relative Value fee schedule.

For 1962-63 we propose to conduct a sample survey of the physicians of Georgia in different specialties for their usual fees for various procedures. This information will serve as a basis of any revision of the Relative Value schedule.

This activity depends upon House of Delegates' approval of the Relative Value Fee Schedule as recommended.

REFERENCE COMMITTEE RECOMMENDATION—The report of this Sub-Committee is approved and its members commended.

HOUSE OF DELEGATES ACTION—Adopted the report of the Relative Value Study Sub-Committee as recommended by the Reference Committee on motion duly made and seconded.

Legislation

J. FRANK WALKER, M.D., *Chairman*

JOHN A. BELL, JR., M.D., *Vice Chairman*

Legislative affairs on the national level continued to dominate the interest of the MAG Board of Legislation for the third consecutive year. State legislation, which is discussed elsewhere in this report, was not neglected or assigned a secondary role. However, due to the greater seriousness of the legislative situation in Washington, namely the King-Anderson bills, it was felt that more time, effort and consideration were needed to help stabilize the situation there than was required for legislation of a purely statewide nature.

During last summer and early fall, the Board of Legislation continued to encourage and help organize a series of legislative breakfasts attended by leading trade, civic, industrial and farm leaders in the respective locations where such breakfasts were held. These breakfast meetings were designed to enlist the support of non-medical people throughout the state, and, in general, to create a climate which would preclude the possible enactment of the social security health care of the aged bill, H.R. 4222. The success of such breakfast meetings must be viewed together with all other efforts in

opposition to the King bill. On this basis our breakfast gatherings have been successful and the Board of Legislation recommends that every County Medical Society consider holding such a meeting as soon after the Annual Session as possible.

During the Congressional recess period (fall 1961) the Legislative Board was instrumental in arranging personal visitation by members of the profession with their own Member of Congress. The purpose of such visits was to engage the support of the Congressmen on this matter and to fully appraise him as to the position of the Medical Association of Georgia on the King bill or any compromise of this bill which relied on the use of the Social Security mechanism to finance or determine eligibility for benefits for our aging, over 65 age group.

The once-a-year Congressional Luncheon to honor members of the Georgia delegation in Washington was held in early June of last year. This annual event was again a huge success and was a great contributor to continued good rapport between our Members of Congress and members of MAG. One member of MAG from each Congressional District made this overnight trip to Washington and the Legislative Board wishes to thank them all for the time they devoted to this occasion. It is anticipated that this year's Washington Legislative Luncheon will be held during the first part of May and that the same format will be followed.

State Legislative Activity

Many important legislative items on the State level occupied the time and efforts of your Board of Legislation during the 1962 session of the Georgia General Assembly.

Of major concern during the 40-day period of the Legislature was a bill so written as to legislate the podiatrist into the Blue Shield plans in Georgia. This bill was passed in the House but finally defeated in the Senate. The defeat of this bill was due solely to the good work done by the Legislative Keymen and by others who contacted their State Senators to register their unremitting protest to this bill.

On the positive side of the State Legislative picture was the enactment of legislation known as the "Good Samaritan" Act. This bill, introduced by S. U. Braly and C. L. Ayers, both M.D.'s and both members of the State Senate, was designed to protect physicians and others from civil liability in instances where emergency treatment, rendered in good faith and without remuneration, is given at the scene of an accident or other disaster. The statesman-like job done by Dr. Braly and Dr. Ayers in the interest of good government in general and good medical legislation in particular deserves the commendation and appreciation of all MAG.

On numerous occasions your Legislative Board was called on to testify before committees of the General Assembly, both for and against legislative items of interest to the medical profession. Among these items were bills dealing with optometry, physical therapy, local county commissions, marriage laws, income tax, pharmacies and pharmaceutical manufacturers and a host of others.

No bill relating to osteopathy was presented at the past session of the General Assembly. However, for the previous 14 years the Osteopathic Association has sponsored legislation designed to bestow full practice privileges upon anyone in possession of an osteopathic

license. Your Board of Legislation would take this occasion to remind the House of Delegates that there is no longer a national or AMA policy on osteopathy on which the individual states may rely. On the contrary, the relationship of osteopathy to medicine is now a matter which must be determined locally on the State level.

Your Board feels that the Osteopathic Association will, in all probability, attempt to have enacted at the next session of the General Assembly legislation which would grant to osteopaths full practice privileges.

Your Board is reluctant to make a specific recommendation on this matter inasmuch as the precise language of an "osteopathic bill" is unknown at this time. Indeed we cannot be certain that such a bill will be introduced at the next meeting of the General Assembly. However, owing to the possibility that one might, plus the fact that the House of Delegates meets only once a year, the Board of Legislation would like to make the following recommendation. It is requested that the House of Delegates confer upon the MAG Council the specific authority to act in the best interest of MAG should a bill relating to practice privileges for osteopaths be presented at the next session or some succeeding session of the General Assembly. And further, that this same specific authority be conferred upon the Executive Committee of Council should occasion demand the use of this authority between meetings of the Council. We must even consider the possibility of some form of joint Board as has proven effective in other states, e.g., Tennessee.

Commendation

The Board of Legislation would like to acknowledge the sincere and invaluable assistance rendered by Mr. Francis Shackelford and Mr. John Moore, legal counsel to the Medical Association of Georgia. Their cooperation with the Board of Legislation was at all times commendable and without their assistance the work of the Board would have been greatly hampered. Any successes of this Board are in great part related to the outstanding work of Mr. Jim Moffett, Assistant Secretary assigned to the Legislative Board.

Other Legislative Activity

The County Legislative Keyman system has been gradually enlarged to the point where we now have a keyman for legislation in 132 counties. The extension of this system proved to be of great value during the past session of the Legislature. They were called on many times to perform their primary function, which is, direct contact with County Representatives to the General Assembly in an effort to persuade them on a given matter.

The Legislative Board has broadened its horizons during the past year to engage in myriad activities relative to the field of legislation. Among these activities was the sponsorship of a WHAM (Women Help American Medicine) Conference, which brought to Georgia a team of experts from the Legislative Department of AMA, and also "piped in" a talk by Congressman Durwood G. Hall from Washington via telephone.

The Board has continued its efforts to improve communications between members of the medical profession and political leaders on the State and national level.

Other activities in the communications field included the distribution of Communications Kits to all Presi-

dents and Secretaries of County Medical Societies in the State. In addition volumes of pamphlets and other materials have been distributed through the Auxiliary to MAG for placement in physicians' waiting rooms. Also similar materials have been distributed to drug stores all over the State and to insurance companies for redistribution in a manner to be determined by them.

In conclusion, your Board recommends that increased emphasis be placed on legislative and political affairs of the State and the nation by each of the County Medical Societies in MAG. And further, that a portion of as many monthly meetings as possible, consistent with practicality, be devoted to legislative affairs. It is the feeling of the Board that a new awareness of the effect of political action on the future of the medical profession must be obtained. It is further the feeling of the Board that this awareness must spring from the "grass roots" county level and it recommends the above policy as a means to accomplish this objective.

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and highly commends the considerable amount of work done by the Chairman and Vice Chairman of the Legislative Board.

HOUSE OF DELEGATES ACTION—Adopted the report of the Legislative Board as recommended by the Reference Committee on motion duly made and seconded.

Supplementary Report of Council No. A

GOV. AND MRS. VANDIVER MENTAL HEALTH COMMENDATION

GEORGE ALEXANDER, M.D., *Council Chairman*

The Council of the Medical Association of Georgia meeting March 17-18, 1962 did recommend and refer to the Association House of Delegates for approval a resolution of commendation for Governor S. Ernest Vandiver and Mrs. Vandiver for their activity in the field of Mental Health as follows:

Whereas, Governor S. Ernest Vandiver initiated and instituted continued improvements in patient care at the state mental institution at Milledgeville, and

Whereas, under the personal leadership of Governor Vandiver, Georgia's program in the field of Mental Health has made great and meaningful forward strides, and

Whereas, Governor and Mrs. Vandiver have led a fund raising campaign to establish Chapels for all Faiths to be built at the State Mental Institution as an adjunct of better patient care,

Therefore, be it resolved that the House of Delegates of the Medical Association of Georgia does hereby commend and praise Governor and Mrs. S. Ernest Vandiver for their activities in the field of Mental Health, and

Be it further resolved that this Resolution be transmitted forthwith to Governor and Mrs. S. Ernest Vandiver as representative of the appreciation of the 3,000 doctors of medicine comprising the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION—Supplementary Report of Council No. A: Governor and Mrs. Vandiver Mental Health Commendation. This report is approved in its entirety.

HOUSE OF DELEGATES ACTION—Adopted the Supplementary Report of Council No. A: Governor and Mrs. Vandiver Mental Health Commendation, as recommended by the Reference Committee on motion duly made and seconded.

Supplementary Report of Council No. B

HARDMAN AWARD SELECTION REVISION

GEORGE ALEXANDER, M.D., *Council Chairman*

At the Council of the Medical Association of Georgia meeting December 9-10, 1961, the Council approved and referred to the House of Delegates for final approval the following proposed revision in the mechanics of selecting the MAG Hardman Award recipient:

MAG to receive nominations made at the first Association General Business Session in conjunction with the Annual Session and such nominations to be given to a nine (9) man secret committee appointed by the President, with the Deans of the two Georgia Medical schools to serve as members and the President of MAG as Chairman for the selection of the Hardman Award recipient. The Council further recommended that this revision be effective at the 1963 Annual Session and thereafter, if approved by the 1962 House of Delegates.

At the present time the Hardman Award (for scientific attainment) recipient is elected by the MAG House of Delegates at their first session from nominations submitted to MAG at the Association's first General Business Session.

REFERENCE COMMITTEE RECOMMENDATION—Supplementary Report of Council No. B: Hardman Award Selection Revision. This report was considered. It is felt that on line eight after the seventh word, "or their representatives" should be added. (This would make the second paragraph of the Supplementary Report of Council No. B read as follows: "MAG to receive nominations made at the first Association General Business Session in conjunction with the Annual Session and such nominations to be given to a nine-man secret committee appointed by the President with Deans of the two Georgia medical schools or their representatives to serve as members and the President of MAG as Chairman for the selection of the Hardman Award recipient . . ."). We so recommend this addition to this Resolution and then recommend its approval.

HOUSE OF DELEGATES ACTION—Adopted the Supplementary Report of Council No. B: Hardman Award Selection Revision, as recommended by the Reference Committee and the additional recommendation of the Reference Committee on motion duly made and seconded.

Supplementary Report of Council No. C

DISCIPLINARY BOARD (A STATE AGENCY)

GEORGE H. ALEXANDER, M.D., *Council Chairman*

At the December 1961 meeting of Council the Legislative Board was instructed to make a study of Disciplinary Boards in other States with a view toward making a report to Council. The intent of Council was clear in that it wished to be advised on the status, language and workability of such Boards in other States in order that it might make a determination as to the desirability of such a Board in the State of Georgia.

Council's attention in this instance was directed toward the possible creation of a disciplinary board which would be organized pursuant to an Act of the General Assembly. As such, this board would be an official agency of the State Government, empowered to act with the authority of law.

The Legislative Board was not asked to recommend that legislation to accomplish this objective be introduced or not be introduced; but merely to make a report to Council in order that Council might be armed

with sufficient knowledge of the entailments to make its own decision and recommendation to the House of Delegates. What follows is the essence of the report made by the Legislative Board to the Council.

A study of existing statutes in other States in this area seemed to indicate that the best example for MAG to emulate, should it decide that such a board would be desirable, is that of the State of Washington where such a board has been in operation since March 16, 1955.

To acquaint you with what all an Act of this nature involves, I would like to review the contents of the Washington State Law. To do this I will quote from selected highlights of this Act.

"BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

SECTION 1. This act is passed:

(1) In the exercise of the police power of the state to protect public health, to promote the welfare of the state, and to provide an adequate public agency to act as a disciplinary body for the members of the medical profession licensed to practice medicine and surgery in this state;

(2) Because the health and well-being of the people of this state are of paramount importance;

(3) Because the conduct of members of the medical profession licensed to practice medicine and surgery in this state plays a vital role in preserving the health and well-being of the people of the state; and

(4) *Because the agency which now exists to handle disciplinary proceedings for members of the medical profession licensed to practice medicine and surgery in this state is ineffective and very infrequently employed, and consequently there is no effective means of handling such disciplinary proceedings when they are necessary for the protection of the public health.*

SECTION 3. The term "Unprofessional conduct" as used in this act shall mean the following items or any one or combination thereof:

- (1) Conviction in any court of any offense involving moral turpitude, in which case the record of such conviction shall be conclusive evidence;
- (2) The procuring, or aiding or abetting in procuring a criminal abortion;
- (3) Fraud or deceit in the obtaining of a license to practice medicine;
- (4) All advertising of medical business which is intended or has a tendency to deceive the public or impose upon credulous or ignorant persons and so be harmful or injurious to public morals or safety;
- (5) All advertising of any medicine or of any means whereby the monthly period of women can be regulated or the menses reestablished if suppressed;
- (6) The personation of another licensed practitioner;
- (7) Habitual intemperance;
- (8) The use or prescription for use of narcotic drugs in any way other than for therapeutic purposes;
- (9) The offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any human condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the board;

- (10) The willful betrayal of a professional secret;
- (11) Repeated acts of immorality, or repeated acts of gross misconduct in the practice of the profession;
- (12) Unprofessional conduct as defined in chapter 19.68 RCW;
- (13) Aiding or abetting an unlicensed person to practice medicine; or
- (14) Declaration of mental incompetency by a court of competent jurisdiction.

SECTION 4. There is hereby created the "Washington state medical disciplinary board," which shall be composed of one holder of a valid license to practice medicine and surgery from each congressional district now existing or hereafter created in the state. The board shall be an administrative agency of the state of Washington. The attorney general shall be the advisor of the board and shall represent it in all legal proceedings.

SECTION 5. Members of the board shall be elected by secret mail ballot by the holders of licenses to practice medicine and surgery residing in each congressional district and shall hold office until their successors are elected and qualified. Members from even-numbered congressional districts shall be elected in even-numbered years and members from odd-numbered congressional districts shall be elected in odd-numbered years.

SECTION 6. Nominations to the board may be made by petition signed by not less than twenty-five license holders residing in the nominee's district, and shall be submitted to the board at least four weeks prior to the date of the election. Votes cast for license holders not so nominated shall be valid.

SECTION 11. The board shall be immune from suit in any action, civil or criminal, based upon any disciplinary proceedings or other official acts performed in good faith as members of such board.

SECTION 15. The board shall have the following powers and duties.

(2) To investigate all complaints and charges of unprofessional conduct against any holder of a license and to hold hearings to determine whether such charges are substantiated or unsubstantiated;

(4) To issue subpoenas and administer oaths in connection with any investigation, hearing, or disciplinary proceeding held under this act.

(5) To take or cause depositions to be taken as needed in any investigation, hearing, or proceeding.

SECTION 19. *Subpoenas issued by the board to compel the attendance of witnesses at any investigation of hearing shall be served in accordance with the provisions of chapter 5.56 RCW, governing the service of subpoenas in court actions Any failure to obey such order of the court may be punished by the court as a civil contempt may be punished.*

SECTION 23. If a majority of the members of the board then sitting vote in favor of finding the accused guilty of unprofessional conduct as specified in the charges, or any of them, the board shall prepare written findings of fact and may thereafter prepare and file in the office of the director of licenses a certificate or order of revocation or sus-

pension, in which case a copy thereof shall be served upon the accused, or the board may reprimand the accused, as it deems most appropriate.

SECTION 28. Any person whose license has been revoked or suspended by the board shall have the right to a judicial review of the board's decision. Such review shall be initiated by serving on the secretary a notice of appeal either in the superior court of Thurston county, or in the superior court of the county in which the appellant resides, within thirty days after the filing of the certificate or order of revocation or suspension in the office of the director of licenses.

SECTION 30. The findings of the board, if supported by the preponderance of evidence, shall be final and conclusive. The review in the superior court shall be limited to determining whether the findings of the board are supported by the preponderance of evidence and whether the proceedings of the board were erroneous as a matter of law, or in violation of due process, or so arbitrary or capricious as to amount to an abuse of discretion, or contrary to any constitutional right, power, privilege or immunity."

So ends the review of the Washington State Medical Disciplinary Board Act as made by J. Frank Walker, Chairman of the Board of Legislation at the March 1962 meeting of Council.

Council voted to endorse the idea of a Medical Disciplinary Board in Georgia. However, due to the seriousness of this matter, decided that it should be referred to the House of Delegates for final determination. Council, therefore is asking the House of Delegates to authorize Council, and thus the Board of Legislation to undertake (1) the responsibility to see that a bill for introduction to the General Assembly at its 1963 session, similar to the Washington State Act be drawn, (2) make the proper and necessary arrangements for such a bill to be introduced at the next session of the General Assembly, and (3) encourage enactment of such a bill at the proper time.

The selection of the Washington State Act as a model in no way suggests that the problems experienced by the medical profession in Washington in any way resembles our problems in Georgia. They may be the same but in all probability they are quite different. The constitutionality of some features of the Washington Act may be in question when viewed in light of Georgia Law. Such questions would have to be resolved by legal counsel and are not the proper consideration of this Reference Committee. What is at issue here is should the medical profession through MAG sponsor legislation which would grant to physicians the legal authority to discipline other members of the profession. Your approval of this Supplementary Report will mean that you are in agreement with Council and that some type of disciplinary board other than what is presently available should be constituted. Your disapproval of this Report would mean that either our present system is adequate, or that some other method should be explored.

REFERENCE COMMITTEE RECOMMENDATION — Supplementary Report of Council No. C: Disciplinary Board. This report is approved and this Committee is in agreement with Council as to the need for Disciplinary Board other than that which is presently available.

HOUSE OF DELEGATES ACTION—Adopted the Supplementary Report of Council No. C: Disciplinary Board, as recommended by the Reference Committee on motion duly made and seconded.

Supplementary Report of the Committee on Professional Conduct No. D

OSTEOPATHIC FACILITIES (HOSPITALS)

WILLIAM P. HARBIN, JR., *Chairman*

The Professional Conduct Committee was asked by the MAG Executive Committee to make a report to the House of Delegates on the matter of licensure of osteopathic hospitals and allied matters concerning pathologists who might be making tissue reports for such osteopathic facilities.

The conclusion reached by the Committee after its deliberation on this matter hinged on two points. They were: (1) that the name hospital implies that such a facility is staffed by doctors of medicine, and (2) that until the policy governing the relationship between medicine and osteopathy is changed locally professional relationships between the two are considered unethical by the Medical Association of Georgia.

Accordingly, the Committee on Professional Conduct recommends to the House of Delegates that any domicile operated by osteopaths, by definition cannot be called a hospital, and at this time doctors of medicine should not participate in the operation of such an institution.

REFERENCE COMMITTEE RECOMMENDATION — Supplementary Report of the Committee on Professional Conduct No. D: Osteopathic Facilities (hospitals). It is recommended by the Reference Committee that in paragraph three, second line, that the words "any domicile operated by osteopaths, by definition cannot be called a hospital, and " be deleted. The third paragraph, therefore, is changed to read: "accordingly the Committee on Professional Conduct recommends to the House of Delegates that at this time doctors of medicine should not participate in the operation of such an institution or domicile operated by osteopaths, as to do so would be unethical."

The Reference Committee recommends this change and then its adoption by the Delegates.

HOUSE OF DELEGATES ACTION—Adopted Supplementary Report of the Committee on Professional Conduct No. D: Osteopathic Facilities (hospitals), as amended by the Reference Committee on motion duly made and seconded.

Resolution No. 3

CONFIDENTIAL NATURE OF CERTAIN HEALTH RECORDS

LESTER RUMBLE, JR., M.D. OF FULTON COUNTY
MEDICAL SOCIETY

Whereas, much of the progress in continuing medical education consists of an honest exchange of opinion between physicians; and

Whereas, such honest exchange might be interpreted by uninformed individuals as an indication of improper medical care; and

Whereas, on certain occasions records of tissue committees, audit committees, research committees, and other groups dealing with continuing medical education have been subpoenaed for use in courts of law;

Be it resolved that the Medical Association of Georgia instruct its legislative committee to draft and press for passage an Act by the Legislature of the State of Georgia providing for the confidential character of medical studies conducted by the Georgia Department of Public Health, the Medical Association of Georgia

and its allied medical societies, and the in-hospital staff committees of accredited hospitals, and providing a penalty for the violation thereof. This Act should further make such information, records, reports, statements, notes, memoranda or other data not admissible as evidence in any action of any kind in any court or before any tribunal board, agency or person.

REFERENCE COMMITTEE RECOMMENDATION — Resolution No. 3: Confidential Nature of Certain Health Records. This report is received for information. The Committee feels that it should be referred to the Legislative Committee for its study and proper action.

HOUSE OF DELEGATES ACTION—Adopted the recommendation of Reference Committee No. 3 concerning the disposition of Resolution No. 3: Confidential Nature of Certain Health Records, on motion duly made and seconded.

Resolution No. 5

INSURANCE COVERAGE FOR MENTAL ILLNESS

WALTER SHEPEARD FOR GEORGIA PSYCHIATRIC
ASSOCIATION

Whereas, Hospitalization and Medical Fee Insurance provided by a number of commercial companies as well as by Blue Cross and Blue Shield organizations doing business in Georgia is inadequate, denied by specific exclusions, or by devious means such as the use of an arbitrary definition of a hospital irrespective of its recognized qualifications, and the fact that the insured often believes that *all* illnesses are covered; and

Whereas, Many commercial insurance companies doing business in Georgia, as well as a number of Blue Cross and Blue Shield organizations in other states, give full coverage to patients with mental illness as readily as they do for any medical or surgical illness; and, in recent years more Blue Cross and Blue Shield organizations and commercial companies have revised their individual and group policies accordingly; and,

Whereas, The Georgia Psychiatric Association, the Georgia Mental Health Association, the National Association of Private Psychiatric Hospitals and other interested groups, have given acclamation for insurance coverage for mental illness without restrictions or exceptions; and,

Whereas, The Governor's Conference on Mental Health which met in Chicago Nov. 9-10, 1961, and which was attended and addressed by Governor Vandiver of Georgia, voted approval of several recommendations for the advancement of mental health programs among which was the following: "Item XII. Mental Health Insurance: We shall ask our Insurance Commissioners to request companies admitted to do business in our respective states to review their health insurance plans with a view to including coverage of mental illness;"

Therefore, be it resolved: That the Georgia Psychiatric Association reaffirm its approval of a broad insurance coverage in the State of Georgia for patients with mental illness who require treatment in General Hospitals and in qualified Private Psychiatric Hospitals; and, in support of the above "Item XII, Mental Health Insurance" adopted by the recent Governor's Conference, that we respectfully request our Governor and Insurance Commissioner to lend their efforts for effective revision of insurance plans as soon as pos-

sible for coverage of mental illness by the various commercial companies as well as by Blue Cross and Blue Shield; and

Be it further resolved: That the Georgia Psychiatric Association, in its effort to hasten this insurance revision as an important part of our current Mental Health Program, instruct the secretary to send a copy of this Resolution to the Honorable Ernest Vandiver, Governor; to the Honorable Zack Cravey, Comptroller General and the Insurance Commissioner; to the Georgia Mental Association; the Atlanta Mental Health Association; to the Insurance Committees of the Fulton County Medical Society and the Medical Association of Georgia; to the Directors of the Georgia groups of Blue Cross and Blue Shield; and to each member of this Association who will see that a copy of this Resolution be forwarded to any insurance company which to his knowledge, excludes the coverage of mental illness by direct or indirect methods.

REFERENCE COMMITTEE RECOMMENDATION—Resolution No. 5, Insurance Coverage for Mental Illness. This Resolution is approved.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 5: Insurance Coverage for Mental Illness, as recommended by the Reference Committee on motion duly made and seconded.

Resolution No. 8

FEE SCHEDULE FOR ANESTHESIOLOGISTS

A. J. WATERS FOR GEORGIA SOCIETY OF ANESTHESIOLOGISTS

Whereas, the proposed National Blue Shield Senior Citizens' Plan presents one of the same major defects of the proposed King-Anderson bill; namely, that it is a national plan, to be administered on a national level, with little or no opportunity for adjustment to local conditions or customs and no effective provision for grievance settlement or for local review, and

Whereas, this Plan contains certain obvious inequities both for patients and for anesthesiologists which will destroy its effectiveness as a stop-gap against King-Anderson type legislation, and

Whereas, we have seen no evidence of willingness on the part of those hospitals concerned with Blue Cross phase of this program to permit a reduction in cost of the Plan by accepting decreased benefits on a service basis, and

Whereas, the cost of this Plan to contract-holders will be such as to make the Plan unattractive to any of the proposed covered group other than those financially able to care for themselves, and

Whereas, most of the members of this Society base their fees largely on duration of service, the proposed Blue Shield Plan makes no provision for time spent in rendering anesthesia services, and

Whereas, the proposed Blue Shield program will greatly increase the inequitable discrepancy between payments for anesthesia of equivalent duration made by Blue Cross and Blue Shield, and

Whereas, this discrepancy of payment will financially penalize those patients not in the service category who elect to utilize the services of anesthesiologists in private practice rather than hospital-employed anesthetists, and

Whereas, this discrepancy of payment might tend to influence those covered by this proposed Plan, to seek out anesthesia service provided by hospital em-

ployees even though many are poor anesthesia risks and need the most highly trained specialist in this field.

Whereas, this discrepancy in compensation between Blue Cross benefits and those provided under this proposed Plan might encourage anesthesiologists to seek employment by hospitals, thereby disposing of their professional services to lay groups for profit thereto, which disposition has been condemned as unethical by many medical organizations including the American Society of Anesthesiologists and the American Medical Association, and

Whereas, there is no provision under the proposed Plan for reimbursement to those anesthesiologists who themselves furnish drugs and equipment necessary to the rendering of their services.

Therefore, be it resolved:

I. That the Georgia Society of Anesthesiologists strongly urges the disapproval by the House of Delegates of the Medical Association of Georgia of the Proposed National Blue Shield Senior Citizens' Plan, as now presented.

II. That this Society strongly urges disapproval of any plan which embodies an anesthesia fee schedule which is not based on "procedural" and "time" factors.

III. That this Society recommends that consideration be given to the elimination of anesthesia benefits from Blue Cross contracts.

IV. That this Society recommends that serious consideration be given to the adoption for this purpose of the anesthesia relative value schedule embodied in the 1960 Relative Value Studies published by the California Medical Association, which schedule comprises a combination of "procedural" and "time" factors.

REFERENCE COMMITTEE RECOMMENDATION — Resolution No. 8: Fee Schedule for Anesthesiologists. This Resolution will be considered paragraph by paragraph.

The first paragraph is disapproved due to the previous acceptance by this Committee of the majority report of the Insurance and Economics Committee:

Paragraph No. 2 is approved.

Paragraph No. 3—The Reference Committee feels that until the anesthesiologists clarify their position with both the hospitals and the Blue Shield and Blue Cross programs that this consideration is beyond our jurisdiction.

Paragraph No. 4 is approved.

HOUSE OF DELEGATES ACTION — Adopted the Reference Committee recommendation on Resolution No. 8: Fee Schedule for Anesthesiologists on motion duly made and seconded.

It was moved by Chairman Reid Gullatt of Reference Committee No. 3 and duly seconded that the report of the Reference Committee as amended be approved and it was so ordered.

Report of Reference Committee No. 4

Braswell Collins, M.D., Chairman

(The following reports as presented to this Reference Committee are printed in full with the Reference Committees recommendations and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 4 met in Room 400 at the DeSoto Hotel, May 7, 1962. Members present

were: Braswell Collins, Macon, Chairman; T. Q. Spitzer, Chamblee, Secretary; W. C. Coles, Atlanta; Lawrence Lee, Savannah; J. E. Cantrell, Albany; Leo Smith, Waycross; and George F. Green, Sparta.

First District Councilor

CHARLES E. BOHLER, M.D., Brooklet

This concludes my first year as Councilor of the First District. I have attended all regular and called meetings of council and I have spent a great deal of time attempting to learn the duties of this office.

I wish to express my gratitude to the other and more experienced members of Council, the Executive Committee and MAG Headquarters Staff for their advice and guidance during the past year.

The First District Meeting was held at the Forest Heights Country Club at Statesboro on February 28. The meeting was well attended by members of Georgia Medical Society of Savannah and other members from throughout the First District. The Scientific Session was held during the afternoon and was followed by a social hour and banquet in the evening.

We hope to have a delegate from each of the First District Societies at the annual Session in Savannah.

Our membership has shown an increase during the past year.

Counties and Secretaries	Members December 31, 1961		Members December 31, 1960	
	MAG	AMA	MAG	AMA
Bulloch-Candler-Evans				
Samuel P. Tillman				
Statesboro	22	19	19	17
Burke				
Charles G. Green				
Waynesboro	8	6	8	5
Emanuel				
H. W. Smith				
Swainsboro	7	6	7	7
Jenkins				
A. P. Mulkey				
Millen	2	2	2	2
Screven				
James C. Freeman				
Sylvania	5	5	5	5
Southeast Georgia				
Michael H. Whittle				
Lyons	22	17	21	15
Tri-Liberty-Long-McIntosh				
O. D. Middleton				
Ludowici	2	1	2	2
	68	56	64	53

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the First District Councilor's report.

HOUSE OF DELEGATES ACTION—Adopted the report of the First District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Second District Councilor

GEORGE R. DILLINGER, M.D., Thomasville

During the past year there have been no unusual problems in the Second District. The District continues to function with regular meetings semi-annually, held

on the 1st Thursday in April and October. The District meetings are generally well attended and the programs interesting.

Generally, the interest of the members indicates an increasing awareness of the legislative and socio-economic problems faced by the profession.

Membership is essentially unchanged and stable.

Counties and Secretaries	Members December 31, 1961		Members December 31, 1960	
	MAG	AMA	MAG	AMA
Colquitt				
James T. Flynn				
Moultrie	19	16	18	15
Decatur-Seminole				
M. A. Ehrlich				
Bainbridge	17	15	17	16
Dougherty				
Ben J. Giles				
Albany	47	37	50	37
Grady				
William Morton				
Cairo	5	5	6	6
Mitchell				
A. A. McNeill, Jr.				
Camilla	11	9	11	9
Southwest Georgia				
R. E. Jennings				
Arlington	14	12	13	11
Thomas Brooks				
Julian B. Neel				
Thomasville	42	36	40	32
Tift				
P. W. Lucas				
Tifton	15	9	14	11
Worth				
H. G. Davis				
Sylvester	5	4	4	4
	175	143	173	141

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the Second District Councilor's report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Second District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Third District Councilor

FRANK A. WILSON, M.D., Leslie

The Third District has seven organized societies. These vary in number of meetings and degree of activity. The Fall meeting was held in Hawkinsville with an excellent scientific program, profitable business meeting and a most enjoyable dinner and entertainment. The Spring meeting will be held in Perry with the Peach Belt Society as host.

The Councilor has attended all regular and called meetings of the Council.

Counties and Secretaries	Members December 31, 1961		Members December 31, 1960	
	MAG	AMA	MAG	AMA
Ben Hill-Irwin				
C. Morgan Smith, Jr.	8	7	8	7
Flint				
W. Kelvin Lane				
Ashburn	17	14	16	13

Peach Belt				
M. W. Anders				
Warner Robins	28	24	24	21
Ocmulgee				
Blake S. Bivins				
Cochran	14	11	13	10
Randolph-Terrell				
R. B. Martin, III				
Cuthbert	12	9	11	9
Sumter				
Frank A. Wilson, III				
Leslie	22	19	22	20
Taylor				
E. C. Whatley				
Reynolds	4	2	5	1
	105	86	99	81

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the Third District Councilor's report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Third District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Georgia Medical Society Councilor

WALTER E. BROWN, M.D., *Savannah*

During the last fiscal year I attended all of the MAG Council meetings and reported back all the pertinent actions taken in the Council.

The Georgia Medical Society has had a most successful year in attendance and in scientific plans and programs. We have every active practicing physician in Savannah as a member of the Georgia Medical Society. We have had an unusually good attendance at all meetings and we feel that this is due in great part to the activity of our Scientific Committee, who has worked very diligently to provide excellent programs for our meetings.

We have taken an active part in politics in contacting not only our local First District Congressmen and Senators, but have also been able to contact five other Georgia Congressmen relative to pending legislation, and have stated to them our position and outlined our feelings as to what actions should be taken concerning this legislation.

We have had only two minor disciplinary problems to come up and these have been amicably settled at the local level.

Counties and Secretaries	Members December 31, 1961		Members December 31, 1960	
	MAG	AMA	MAG	AMA
Georgia Medical Society				
Jeff J. Holloman				
Savannah	153	138	155	137

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the Georgia Medical Society Councilor's report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Georgia Medical Society Councilor as recommended by Reference Committee on motion duly made and seconded.

Muscogee County Councilor

W. P. JORDAN, M.D., *Columbus*

The Councilor from Muscogee County has attended the monthly Executive Committee meeting and all busi-

ness meetings of Muscogee County Medical Society and endeavored to keep them informed as to activities of the Council and MAG.

Counties and Secretaries	Members December 31, 1961		Members December 31, 1960	
	MAG	AMA	MAG	AMA
Muscogee				
C. Denton Johnson				
Columbus	107	99	104	97

Muscogee County Vice Councilor

LUTHER H. WOLFF, M.D., *Columbus*

The Vice Councilor representing the Muscogee County Medical Society attended the majority of Council Meetings during the past year. A particular effort was made to attend when the Councilor was unable to meet with Council.

With the reorganization of MAG Committees under the Board system, the Vice Councilor, as Chairman of the Board on Governmental Medical Service, was able to carry on an effective liaison between Council and the various subcommittees of the Board of Governmental Medical Services. It appears that the reorganization of committees under Boards will materially assist Council in understanding and evaluating the work of the many and diversified subcommittees.

The Vice Councilor has reported to the Muscogee County Medical Society various aspects of Council activity. It is believed that a closer relationship between MAG and the County Societies exists resultant from the recent reorganization of Council.

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the Muscogee County Medical Society Councilor and Vice Councilor reports.

HOUSE OF DELEGATES ACTION—Adopted reports of the Muscogee County Medical Society Councilor and Vice Councilor as recommended by the Reference Committee.

Hospital Activities

RALPH N. JOHNSON, M.D., *Chairman*

While this Board has done nothing tangible during the past year, it is our earnest desire to maintain pleasant public relations between the doctors and the hospitals with their component parts. That is, the nursing staff, dietitians, laboratory and X-ray personnel, blood bank, etc.

The patient's comfort and happiness should be foremost in all hospitals.

We realize that there is a shortage of registered nurses in Georgia and the ones whom we have are concentrated in the larger cities. The hospitals in the smaller cities are using the registered nurses in supervising the various departments of the hospitals and in instructing the practical nurses and other helpers but it would be very desirable to have more registered nurses. We wish that some effort could be made to get more high school seniors interested in the field of nursing. Industry and matrimony have taken a lot of our nurses away from the hospitals and they should be replaced. There is also a shortage of private duty nurses. We will welcome any suggestions that might stimulate more interest in the nursing field. With more Hill-Burton hospitals being erected and additions being

made on the existing ones, there is a definite need for more nursing personnel.

Some of the cities still have their own Blood Banks. They are to be encouraged because of the convenience of procuring blood in the shortest length of time. We are sure that the Red Cross will cooperate in trying to supply blood when it is needed but the doctors and hospitals in Georgia should be encouraged to set up their own blood banks when practical.

With the hospital expansion program in Georgia, there is also a greater demand for laboratory technicians. We hope that these persons can be trained in sufficient numbers to supply the demand.

Our Board is new and inexperienced and we will welcome any suggestions from the Georgia doctors as to how we may function more efficiently.

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the Hospital Activities Board report. We further suggest that female high school students be encouraged earlier than the senior year to become interested in nursing by giving them light hospital temporary assignments.

HOUSE OF DELEGATES ACTION—Adopted the report of the Hospital Activities Board as recommended by the Reference Committee and the additional recommendation of the Reference Committee *en* motion duly made and seconded.

Blood Banks Sub-Committee

JACK C. NORRIS, M.D., *Chairman*

The meeting of the "MAG Sub-Committee on Blood Banks" was called to order by Chairman Jack C. Norris at 1:15 p.m., February 26, 1962, in Room 1012 at the Biltmore Hotel, Atlanta, Georgia.

Those present included Chairman Norris, Atlanta; Walter Sheppard, Augusta, and Irving Greenberg, Atlanta. Also present at the meeting were Dr. Joseph W. Iseman, Atlanta, representing the American Red Cross, Dr. John Venable, Director, Georgia Department of Public Health, and Mr. James M. Moffett, Assistant Executive Secretary, MAG, the liaison officer to the Committee.

Following the luncheon, Chairman Norris made some introductory remarks in which he thanked all those present for attending. He explained that the Committee structure of MAG had been reorganized, and that the Council had expressed a desire for all Boards and Sub-Committees to meet to organize their activities.

Walter Sheppard discussed the matter of giving transfusions, with particular reference to this procedure in our smaller hospitals. He pointed out that the technology of transfusion had outstripped the availability of M.D.'s and properly trained technicians to successfully administer such transfusions without danger to the recipients. He emphasized the danger of "over-use" of blood.

Dr. Sellers Blood Bank Letter

Dr. Norris then read a letter he had received from Dr. Thomas F. Sellers, Director Emeritus of the Georgia Department of Public Health, concerning The Blood Bank Foundation in Atlanta. He pointed out in the letter that he had been informed of two people (one with diabetes and one with cancer) who had been blood donors (sold blood) to the Blood Bank Foundation, and he felt that this matter should be investigated.

Mr. Moffett who visited this bank then gave a report

of his findings on the occasion when he had made a preliminary investigation in this connection. His report will be considered in detail at the 1962 MAG Annual Session in Savannah.

Dr. Iseman stated that NIH regulations (The Blood Bank Foundation operates under NIH licensure) require that an M.D. be available when blood is taken from a donor and that donors are to be given certain medical examinations before bleedings.

Dr. Norris then suggested that Dr. Venable install an investigation committee within the State Board of Health for the purpose of investigation, consultation and inspection of Georgia blood banks. General detailed discussion followed this suggestion. Dr. Venable commented that in his view the problem comes under three general headings, to wit: (1) Supply of blood. He pointed out that there is a shortage of blood, and illustrated his point by stating that the State TB Hospital had to go outside to purchase necessary blood; (2) Collection and storage of blood; (3) Administration of blood to include matching and greater safety requirements. He said he is of the opinion that an agency of Government, such as the State Public Health Department, should be concerned mostly with item two, collection, storage and distribution of blood. He stated that he would resist any move to give the state this responsibility unless it were also given authority to do something about such conditions as may be uncovered. He felt further that he would need legal authority, including "right of entry." He also pointed out that standards must also be adopted.

Dr. Venable reported that the State Health Department is presently gathering information from other States on this problem. He added that intensive study must be given before a stand is taken.

Dr. Sheppard expressed himself by saying that the whole matter should be given extensive publicity by MAG as the first step. He also suggested a training school for Blood Bank Technicians at Milledgeville.

On motion (Norris-Venable-Greenberg) the Sub-Committee voted that the Georgia Department of Public Health be requested to consider and undertake necessary studies leading to proposals for possible legislation regarding licensure inspection, etc. of blood banks, at least to the extent of *collection, storage, and distribution*, and should report to the Sub-Committee on Blood Banks and the Executive Committee of Council in Savannah, with a view toward legislation jointly sought by MAG, the Georgia Department of Public Health, and the Committee.

Red Cross Card System

Dr. Iseman discussed briefly the Red Cross Card System and stated that the Red Cross had made an effort to put responsibility for blood on the family of the recipient, and stated further that the system is working out nicely.

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the work of the Blood Bank Sub-Committee for its report. We further suggest that rather than recommending legislation at this time, we revise and publicize the minimum Medical Association of Georgia standards for blood banking and extend them to include distribution.

HOUSE OF DELEGATES ACTION—Adopted the report of the Blood Bank Sub-Committee as amended by the Reference Committee on motion duly made and seconded.

Hospital Relations Sub-Committee

RAFE BANKS, JR., M.D., *Chairman*

Report of Sub-Committee on Hospital Relations:

I am happy to report that there has been very little work for your Sub-Committee on Hospital Relations to do this year. On several occasions we have attempted to meet with the Georgia Nursing Association. However, due to various conflicts they were not able to meet with us. There were no problems forwarded to us.

REFERENCE COMMITTEE RECOMMENDATION—The Committee approves and commends the report of the Hospital Relations Sub-Committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the Hospital Relations Sub-Committee as recommended by the Reference Committee on motion duly made and seconded.

Occupational Health

T. A. PETERSON, M.D., *Chairman*

As Chairman of the Board of Occupational Health, I attended the American Medical Association Congress on Occupational Health which was held in Denver, Colorado. I have discussed with various members of the Medical Association of Georgia the inadequacies of workman's compensation fee schedules. It is my firm belief that we need not a revision of the fee schedule with a paid trend, but that we need an open fee schedule without limitations because the major industries have learned the safeguard of the health of the employees and the production of the employees following injury is the best investment they make and that the proofs of top grade medical care is best done without restrictions and limitations.

As Chairman of this Occupational Health Board, it was necessary for me to appoint a new Chairman of the Rural Health committee to replace Charles E. McArthur. New Chairman appointed was Reid Gullatt, of Cochran, Georgia. No meetings of the Board were held as I felt no matters presented themselves that would require a full Board meeting.

REFERENCE COMMITTEE RECOMMENDATION—After studying the Occupational Health Board report, it is recommended that the fee schedule should be revised upward rather than proposing open fee schedules without limitation.

HOUSE OF DELEGATES ACTION—Adopted the Occupational Health Board report as amended by the Reference Committee on motion duly made and seconded.

Public Service

LINTON BISHOP, M.D., *Chairman*

The Public Service Board held one formal meeting and two informal meetings during the Association year 1961-62. Liaison has been maintained between the Board and its Sub-Committees, which include Weekly Health Column and Public Service.

As Board Chairman, I wish to recognize the excellent activity of the Board Sub-Committees. The Weekly Health Column Sub-Committee, under the leadership of August Yochem, prepares and distributes a "health advice" column each week to all of the weekly and daily newspapers in Georgia for publication. The Sub-Committee of Public Service as guided by Joseph Mercer has cooperated with the Board in many projects.

Perhaps the most important single project was the MAG 4th Annual County Medical Society Officers Conference held February 17-18, 1962. This Conference was devoted to certain public service projects for county medical society implementation. Some 72 county society Presidents and Secretaries were in attendance at this two-day session held at the Dinkler Plaza Hotel, Atlanta. The meeting was judged to be successful and our Board recommends its continuance.

Future activity of our Board will concern itself with communication between the physician and his public. Telling medicine's story is one of our prime aims—so that the public will achieve a better understanding of the practitioner. Our Board will also continue to sponsor public service projects for the State Association and recommend certain projects for consideration of component county medical societies. We also plan a state conference on Medicine and Religion to improve liaison between these professions in the interest of improved patient care.

REFERENCE COMMITTEE RECOMMENDATION—The Committee concurs with the Public Service Board on its recommendation for continuance of the County Medical Society Officers Conference. The Committee commends them for their plans for closer liaison between medicine and religion.

HOUSE OF DELEGATES—Adopted the report of the Public Service Board as recommended by the Reference Committee on motion duly made and seconded.

Weekly Health Column Sub-Committee

AUGUST S. YOCHER, M.D., *Chairman*

The Weekly Health Column Sub-Committee was organized in 1958 and has been a very active committee. The Committee has met every three months during the past year and has prepared 53 articles for publication. These articles have been on subjects of popular interest concerning disease, conditions and situations related to medical and health care.

The Health Column is mailed to 235 weekly and daily newspapers in Georgia. Of the weekly newspapers an average of 200 publish the articles each week, and of the daily newspapers an average of ten publish the articles each week.

The committee is still assisted by the professional science writer who helps in editing the columns, and who continues to do an excellent job.

The Chairman recommends continuance of this project in the interest of serving the citizens of Georgia. The local medical societies have been encouraged to inform and stimulate their local weekly and daily newspaper publishers to take advantage of this MAG service, and the editors have also been contacted by MAG. At the end of each article a statement asking for letters regarding subjects of interest to the readers has been inserted and a number of replies have been received.

There have been a few committee changes in the past year due to the fact that active participation is required. Each member is asked to bring two articles at the time of each meeting, and it is sometimes impossible to make contributions to this column due to a heavy work load. During the past year it was suggested that at least two members be appointed from each specialty to obtain a varied supply of papers. The Chairman recommends that future appointments be made to this committee on a rotating basis for a limited

period of time, as the work of this committee is rather demanding.

I wish to thank the members of the Council and the Finance Committee for their interest and support in this important project. I also wish to commend all of the members of the Committee who worked so diligently during the year.

REFERENCE COMMITTEE RECOMMENDATION—The Committee commends and approves the Weekly Health Column Sub-Committee on their report and concurs with their recommendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Weekly Health Column Sub-Committee as recommended by the Reference Committee by motion duly made and seconded.

Public Service Sub-Committee

JOSEPH B. MERCER, M.D., *Chairman*

The Chairman of the Sub-Committee on Public Service participated in the activities of the Board of Public Service in planning the County Officers Conference and other duties of the Board. No specific assignments were given the Sub-Committee. The Chairman of the Sub-Committee on Public Service recommends that specific written duties and areas of responsibility be clearly defined and given to each member of the various Boards and Sub-Committees so that they may fully understand the scope of their work.

REFERENCE COMMITTEE RECOMMENDATION—The Committee commends the Public Service Sub-Committee for its report and approves its recommendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Public Service Sub-Committee as recommended by the Reference Committee on motion duly made and seconded.

Woman's Auxiliary to the Medical Association of Georgia

MRS. A. WORTH HOBBS, *President*

Greetings and appreciation to the Medical Association of Georgia! This we say to each doctor and especially to those who form the Advisory Committee to the Auxiliary. Deep gratitude is felt to the MAG Staff also.

Mrs. Harlan English, President of the Woman's Auxiliary to the AMA, announced that the Auxiliary's aim for 1961-1962 is "to strive to make the helping hands of the doctor's wife reflect and enrich the doctors' dedicated service to mankind." From this she took the year's theme, "Speak Your Beliefs in Deeds." With this Biblically based challenge, the Auxiliary has made a superlative contribution in Community Service and good public relations.

Community Service has top priority. Other priorities are Legislation, the AMA's Program for the Aged, Health Careers, and American Medical Education Fund. Priorities are established yearly by National.

Before Committee achievements are highlighted, I shall relate National and State activity, because in time relation, they precede Committee action.

National

The President and six delegates represented our Auxiliary at the National Convention in New York, in June. One of the seven National Directors is Mrs.

Leo Smith, former State President, of Waycross. The Southern Region Chairman of Civil Defense is Mrs. Kells Boland, of Atlanta. The President and President-Elect, Mrs. Ennis W. Waldemayer, of Americus, attended the Woman's Auxiliary AMA Conference for State Presidents, Presidents-Elect, National Officers, and Chairmen in Chicago, in October. The President participated in this Conference by serving on a panel of four State Presidents on the National Safety Council Citation Award Program. Panelists represented states receiving top merit in a Safety Program.

State

The Post Convention Executive Board meeting was held June 10, 1961 in Atlanta at the Convention Hotel, The Biltmore. The Summer Board meeting in Atlanta at the MAG Headquarters Building, July 19-20, 1961, was attended by the Advisory Committee who approved plans for the year and offered helpful counsel. The Winter Board meeting, January 30, 1962, was held at Headquarters Building also. Excellent attendance at all. A WHAM Conference was called for March 21, 1962. (See Legislation.)

Priority Committees

Priority Committee activity follows in bare, summary-inventories, but the amazing achievement of officers, 11 Councilors, and 24 Committees cannot be conveyed herein. I refer you to The President's Report on file at MAG.

Community Service

"Great initiative, judgment, and insight into community needs have been displayed by Community Service Chairmen and their Auxiliaries throughout the state. Auxiliary members have participated actively in practically every phase of constructive community life in Georgia."

Auxiliaries have:

(1) Undertaken projects in the field of Mental Health. One of these was the local sponsorship at Milledgeville State Hospital of the Apparel Shop, garden therapy, music therapy, and numerous parties for patients. Since this institution serves the state, all County Auxiliaries are asked during the year 1962-1963 to send clothing for the Apparel Shop to their local Mental Health associations or directly to the Milledgeville State Hospital. One Auxiliary sent over 45 dozen pairs of socks and 250 pairs of jiffy bedroom slippers to Milledgeville. Many gifts were sent to patients there and at Gracewood. Still other Auxiliaries helped establish and maintain schools for the mentally retarded, and sponsored booths on Mental Health at fairs.

(2) Actively assisted in the drive in Georgia to immunize every person against poliomyelitis. One Auxiliary took over the program of administering the Sabin I vaccine. Forty-three members gave 180 hours of work serving 10,840 people at the community hospital. Members who were nurses gave the vaccine while other members directed human traffic and the paper work, operating in two-hour shifts. This same Auxiliary plans to administer Sabin II in the same manner.

(3) Worked on problems of the Senior Citizen. One Auxiliary set up a recreation center for Senior Citizens

and met with them weekly, furnished refreshments, entertainment, and programs. During the year the membership has tripled. Arrangements were made for high school students and Auxiliary members to make friendly visits to local nursing homes carrying seasonal gifts. One Auxiliary made weekly visits to two nursing homes, took Christmas gifts, etc. An Auxiliary assisted in determining need for nursing home and then worked for bond issue to provide it. Another decorated a nursing home and hospital for Christmas.

(4) Created interest in the Allied Medical Services. This was accomplished through efforts reported herein under "Health Careers," and by initiating a fund for a future nursing school, helping in a bond issue to provide more beds and a teaching program, and sponsoring Health Career booths at county and regional fairs where literature was distributed. One Auxiliary sponsors a Woman's Auxiliary to the Student American Medical Association.

(5) Assisted at openings of new hospitals and health buildings; assisted in bloodmobile and blood bank, gave money, equipment and furniture to hospitals or other community agencies, as, \$200.00 to Empty Stocking Fund, etc. Auxiliaries furnished a child's playroom on the pediatrics floor of a hospital, a recreation room for children in a new Juvenile Detention Home, sponsored a project at Adamsville School for Girls, sponsored a clinic for crippled children, sent sample medicine to an overseas hospital, sent sample medicine to local agencies serving indigent patients, placed prayers on hospital trays on World Day of Prayer, kept fresh flowers in the Prayer Room of a hospital, subscribed to magazines for a county hospital, organized a hospital auxiliary, sponsored a visit of a church choir to a convalescent home at Christmas, made layettes for needy families, and maintained a second-hand clothing store with the money going for community needs. One Auxiliary continued to own and operate a gift shop through which three \$500.00 scholarships, one \$600.00 donation on a medical library, and furnishings for a pediatric playroom have come. One gave \$100.00 to Visiting Nurses' Association Loan Closet. Another serves 12 dinners to doctors' meetings yearly.

used with cancer patients with some members serving as volunteer nurses to make home visits to cancer patients.

(6) Assumed responsibility for rolling all bandages patients, gave a suction machine to Cancer Society for their Loan Closet, and gave \$200.00 to Cancer Society.

(7) Sponsored Pre-School Vision Screening programs, helped in Cerebral Palsy Schools, provided lunches throughout the year for needy children, helped obtain an adequate swimming pool at a state park, and helped obtain fluoridation of water in one town. One gave eight months of specific service to one underprivileged school.

(8) Sponsored and manned booths at county and regional fairs on Mental Health and fallout shelters as well as Health Careers.

(9) Aided miscellaneous. Held Health Education meetings open to the public; sponsored Home Preparedness courses; assisted in a Seminar of American Strategy; held a coffee hour for area service men; gave 81 subscriptions to *Today's Health* to school libraries in county; gave a finished pageant on the spirit of giving, "If I Am Not For Myself," written by a member, Mrs. Neil G. Perkinson; illustrated Mrs. Harlan English's expressed aim for the year, which was given in the

second paragraph of this report, by showing a Caduceus held lightly but firmly by a pair of feminine hands wearing a wedding band.

The above listed activities and programs indicate clearly that the year's theme, "Speak Your Beliefs in Deeds" is alive in Georgia.

Legislation

Four Auxiliaries held or participated in a forum on Legislation; 15 contacted their Congressman regarding bills; four invited Congressmen as speakers; 17 Auxiliaries wrote members of the House Ways and Means Committee; 12 had a program on Legislation; 16 Auxiliaries allotted time at each meeting for discussion of medical bills under consideration; ten participated in "Operation Coffeecup"—one Auxiliary played the Ronald Reagan record to 28 groups, 215 people. Laymen have been informed by pamphlets in doctors' and dentists' offices, hospitals, drug stores, fairs, and in bills. School debates and college groups argued legislation relating to the aged.

On January 30, at the State Auxiliary Board meeting, a resolution was passed "vigorously opposing any type Federal financed health plan." This was sent to President Kennedy, Congressman Mills, and certain members of Congress.

A WHAM, Women Help American Medicine, Conference was held at the MAG Headquarters Building March 21, 1961. About 50 attended and participated with alert interest and cooperation. These will initiate resolutions and letters from their own Auxiliaries.

Health Careers

There are 72 Allied Medical Career Clubs in the state, 42 of which are chartered. Auxiliaries have aided these clubs in programs, transportation, posters, chaparroneage to state Allied Medical Career Convention, entertaining, field trips to hospitals, etc. One Auxiliary provides two scholarships for \$500.00 each, one for white and one for Negro nurses. The same Auxiliary gives a \$500.00 scholarship in Health Careers. Auxiliaries provide eight scholarships, amounting to \$2,026. The State Chairman has information concerning other available scholarships also. Auxiliaries have given pins, capes, dues, charter, etc. One Auxiliary entertains a new group of 75 affiliated nurses, representing seven Schools of Nursing, each quarter.

American Medical Education Fund

By March 14, 1961, 31 of 41 Auxiliaries had contributed \$2,296.10; 16 of these had contributed \$2.00 or more per member; ten had a fund-raising event; five had sold 155 double-decks of A.M.E.F. playing cards; six had a program on A.M.E.F.; 16 had urged use of A.M.E.F. "With Sympathy," "In Appreciation," and All-Purpose cards. These cards are excellent means of expression for doctors and patients.

In Appreciation

As I have traveled over the state and met with as many of our 1827 members as seemed possible, I have observed first-hand the work done by County officers and have seen the firm foundations built and added to by Past State Presidents and their memberships, and I have been awed. I have enjoyed the warm cooperation

and the splendid accomplishments of the Executive Board, — and I have been moved.

All of us, however, have been thankful for the counsel of the Greatest Physician of All and to Him we dedicate the year's work hoping it will be of great future as well as present use to Him.

REFERENCE COMMITTEE RECOMMENDATION—The Committee unanimously approves and gives great commendation for the Woman's Auxiliary. Outstanding among their report is the year's theme "Speak Your Beliefs in Deeds." Their reference to community service is top priority and admirable. The community service, which includes therapy at Milledgeville State Hospital, immunization against poliomyelitis, working on problems of senior citizens, initiating funds for nursing schools, new hospitals and other health facilities, sponsoring pre-school visual screening and sponsoring health booths at regional and county fairs, deserves great appreciation. The symbol "showing a caduceus held lightly but firmly by a pair of feminine hands wearing a wedding band" and the year's theme "Speak Your Beliefs in Deeds" and the abbreviation "WHAM" (Women Help American Medicine) really symbolizes their great work.

HOUSE OF DELEGATES ACTION—Adopted the report of the Woman's Auxiliary to the Medical Association of Georgia as recommended by the Reference Committee on motion duly made and seconded.

Resolution No. 1

LABORATORIES BE SUPERVISED BY QUALIFIED LICENSED PHYSICIANS

GEORGIA ASSOCIATION OF PATHOLOGISTS

Whereas, The practice of pathology, both clinical and anatomical, has been declared repeatedly to be the practice of medicine by the AMA, by state and county medical societies, by the College of American Pathologists, and other special professional societies, by the courts of record having certain legal jurisdictions, and by opinions of record of attorneys general of certain states; and

Whereas, There are medical laboratory technicians and other nonprofessional persons operating independent medical laboratories on a commercial basis without medical licensure, without adequate education or training, and without proper professional supervision; and

Whereas, Persons operating such commercial laboratories are not constrained by law or by their education and training to adhere to professional ethical principles guarding the public interest; and

Whereas, Such commercial laboratories frequently charge fees to physicians under conditions fostering the division of fees between the laboratory and the referring physician; and

Whereas, It is desirable to encourage scientists of professional status, such as chemists and bacteriologists with doctoral degrees, to work cooperatively with physicians for the welfare of patients and in the interest of public health; and

Whereas, The independent practice of laboratory medicine, generally known as pathology, by persons without medical licensure degrades the practice of medicine and of pathology in particular, is against the public interest and seriously lowers the medical and scientific standards of medical practice; and

Whereas, The medical profession generally has always placed the common good above self-interest and has adhered to ethical and moral principles, now, therefore, be it

Resolved, That the Medical Association of Georgia hereby declares that the proper conduct of laboratory analyses is a medical professional responsibility and all specimens for such analysis should be referred to laboratories supervised by fully qualified and licensed physicians.

REFERENCE COMMITTEE RECOMMENDATION — Resolution No. 1: Laboratories be Supervised by Qualified Licensed Physicians. The Committee recommends that this Resolution be adopted.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 1: Laboratories be supervised by qualified licensed physicians, as recommended by the Reference Committee on motion duly made and seconded.

Resolution No. 2

TRAFFIC SAFETY — REDUCE TRAFFIC DEATHS AND INJURIES

CARROLL-DOUGLAS-HARALSON MEDICAL SOCIETY

The Carroll-Douglas-Haralson Medical Society resolves to urge the officers and members of the Medical Association of Georgia to exert more organized and individual effort to reduce the appalling death and injury rate on Georgia streets and highways. The society further recommends that prompt and sustained action be taken by the MAG and the county medical societies in cooperation with other appropriate organizations to improve traffic safety in Georgia.

REFERENCE COMMITTEE RECOMMENDATION — Resolution No. 2: Traffic Safety-Reduce Traffic Deaths and Injuries. The Committee approves and commends this Resolution and recommends referral to the Public Service Sub-Committee for implementation.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 2: Traffic Safety, as recommended by the Reference Committee and the additional recommendation of the Reference Committee on motion duly made and seconded.

Resolution No. 6

AMERICAN COLLEGE OF SURGEONS' STATEMENTS

JOHN HOOVER FOR WALKER, CATOOSA, DADE MEDICAL SOCIETY

Whereas, the American College of Surgeons has allowed certain of its members in official capacity to make misleading (and we feel, false) statements; and

Whereas, these statements tend to create the wrong impression in the layman's mind regarding surgical procedures, and furthermore tend to create a bad image of doctors in general, and

Whereas, the American College of Surgeons has declined to meet with an official committee from the American Medical Association to discuss the problems;

Therefore, be it resolved: by the Medical Association of Georgia that we hereby make known our official disapproval of these acts and hereby officially censure the American College of Surgeons for said acts.

REFERENCE COMMITTEE RECOMMENDATION — Resolution No. 6: American College of Surgeons' statements. After lengthy hearings were conducted and having been assured by representatives of both organizations involved that paragraph three is presently in error, it is recommended by the Committee that no action be taken at this time.

HOUSE OF DELEGATES ACTION—Speaker Walker called for a discussion of the Reference Committee recommendation on Resolution No. 6 and recognized John Hoover of Rossville. After some

discussion by Dr. Hoover, he moved (John Hoover-T. E. Cummings) in a substitute motion that Resolution No. 6 be approved in its original form.

Speaker Walker called for a vote on the substitute motion and this motion was defeated.

Speaker Walker then called for a vote on the Reference Committee recommendation. The vote was in favor of the Reference Committee recommendation that no action be taken at this time on Resolution No. 6.

It was moved by Chairman of Reference Committee No. 4, Braswell Collins, Macon, and duly seconded that the report of Reference Committee No. 4 be approved as a whole and it was so ordered.

Report of Reference Committee No. 5

H. G. Davis, M.D., Chairman

(The following reports as presented to this Reference Committee are printed in full with the Reference Committees recommendations and the actions pursuant to it taken by the House of Delegates.)

Reference Committee No. 5 met in Room 450, DeSoto Hotel at 2:30 P.M., May 7, 1962. Members present were: H. G. Davis, Sylvester, Chairman; C. S. Britt, Brunswick, Vice Chairman; William Moore, Jr., Atlanta, Secretary; Rafe Banks, Gainesville; J. M. Grisamore, LaGrange; W. F. Castellow, Americus; and F. N. Harrison, Augusta.

Fourth District Councilor

VIRGIL B. WILLIAMS, M.D., Griffin

The Councilor of the Fourth District has attended all regular and called meetings of the Council during the past year.

During the year the Councilor has remained in contact with activities of all societies in his district. Informal consultations have been held with members of the association residing in the Fourth District. Matters concerning policy, organizations and ethics have been observed closely by the Councilor.

The Councilor attended a hearing before the State Board of Medical Examiners concerning the question of an irregular physician practicing in the Fourth District.

The Councilor has been ready at all times to advise on problems pertaining to the office.

Counties and Secretaries	Members December 31, 1961		Members December 31, 1960	
	MAG	AMA	MAG	AMA
Clayton-Fayette				
Wells Riley				
Jonesboro	5	5	5	5
Coweta				
Ulrich H. Harte				
Newnan	17	11	18	8
Lamar				
S. B. Traylor				
Barnesville . . .	4	4	4	4
Meriwether-Harris				
H. Calvin Jackson				
Manchester . . .	14	9	14	7

Newton-Rockdale				
T. L. Crews				
Covington	11	8	12	10
Spalding				
Ira H. Slade, Jr.				
Griffin	43	36	41	37
Troup				
J. T. Mitchell				
LaGrange	40	35	43	36
Upson				
J. H. Woodall				
Thomaston . . .	15	11	15	13
	149	119	152	120

Fourth District Vice Councilor

CHARLES T. COWART, M.D., LaGrange

The Vice Councilor for the Fourth District has attended all the meetings of Council except for one called meeting.

I wish to commend the Medical Association of Georgia for the excellent meeting held February 17 and 18 for the Presidents and Secretaries of County Medical Societies. It was thoroughly enjoyable as well as educational.

Our Headquarters office under the leadership of John Mauldin is certainly progressive and wide-awake, and making giant steps forward and upward. The legislative committee with the magnificent help of Mr. Moffett is doing a commendable job and is gaining more and more prestige at the Capitol.

I certainly favor the fact that MAG is administering Medicare and the Kerr-Mills program rather than contracting it out and some other agent.

REFERENCE COMMITTEE RECOMMENDATION — The Committee accepts and approves the report of the Fourth District Councilor and the Fourth District Vice Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Fourth District Councilor and the Fourth District Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

Fifth District Councilor

FLOYD R. SANDERS, JR., M.D., Decatur

The Fifth District Medical Society has continued to make progress both in membership and medical science during the past year. Many of its members continue to make significant contributions to medical education and to the practice of medicine locally and nationally.

The annual meeting of the Fifth District Medical Society was held on November 3, 1961 at the Academy of Medicine. Dr. W. T. Thompson, Professor and Chairman, Department of Medicine of the Medical College of Virginia, was the guest speaker. He delivered a paper on the "Use and Abuse of Oxygen Therapy." At this meeting L. C. Buchanan (DeKalb County Medical Society) was elected President and Carl C. Jones (Fulton County Medical Society) was elected Secretary-Treasurer. The present Councilor and Vice Councilor were re-elected for a new term of office.

Since the Fulton County Medical Society has its own Councilor and Vice Councilor, I shall not make a specific report on activities there except to state that this

society continues to grow in size and a number of its members hold offices in our state, regional, and national medical associations.

The DeKalb County Medical Society has enjoyed a phenomenal growth period during the past year. This, to a large degree, can be attributed to the opening of the big, new DeKalb General Hospital in Decatur, Georgia on May 1, 1961. The critical need for more and better hospital facilities for DeKalb County and a portion of Fulton County is being met by this fine new institution in a fashion that reflects credit on the medical profession in our community.

There is a source of growing concern over the kind of care being imposed on a segment of our population in the form of an osteopathic facility known as "Doctor's Hospital" at Tucker, Georgia. The existence of a so-called hospital of this kind, is to say the least, very disturbing to the medical profession. Many patients are attracted to such places by the obvious use of misleading titles and through ignorance as to the kind of care offered. This situation again points up the urgent need for proper identification of osteopaths, and a more acute necessity for the medical profession to undertake a program of educating the general public on such matters. I believe this should be done on both local and state levels.

It has been my pleasure to attend all meetings of Council during the year, and to have the able support of your Vice Councilor, L. P. Matthews.

Counties and Secretaries	Members December 31, 1961		Members December 31, 1960	
	MAG	AMA	MAG	AMA
DeKalb				
James E. Anthony				
Decatur	115	99	93	82

REFERENCE COMMITTEE RECOMMENDATION — The Committee accepts and approves the report of the Fifth District Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Fifth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Sixth District Councilor

WILLIAM RAWLINGS, M.D., Sandersville

It has been an honor for your Councilor to fill the unexpired term of George H. Alexander, following his resignation in accordance with plans for reorganization of the Council as approved by Council at its June 1960 meeting.

I have been able to attend all regular and called meetings of Council with the exception of one.

The Sixth District Medical Society had its Fall meeting in Macon and Spring meeting in Milledgeville. Excellent scientific programs were presented at both meetings followed by delightful social hours. The attendance at these meetings has been very good and seems to be improving.

During the year I have transmitted information and requests to our membership at the direction of Council. John Bell of Dublin, our Vice Councilor, has been most cooperative and continues to do most outstanding work for the Association.

Attached is a list of Sixth District membership. It will be noted that less than 50 per cent are AMA mem-

bers. Requests have gone to each member urging his renewing this membership if indicated.

Counties and Secretaries	Members December 31, 1961		Members December 31, 1960	
	MAG	AMA	MAG	AMA
Baldwin				
J. G. Bohorfoush				
Milledgeville . . .	33	16	31	18
Jasper				
E. M. Lancaster				
Shady Dale	3	3	3	2
Jefferson				
John J. Pilcher				
Wrens	7	5	7	4
Laurens				
Quentin Price				
Dublin	30	15	28	14
Washington				
L. R. Harvey				
Sandersville . . .	11	1	11	—
	84	40	80	38

REFERENCE COMMITTEE RECOMMENDATION — The Committee approves and commends the report of the Sixth District Councilor for recognition and work regarding AMA membership of their constituents.

HOUSE OF DELEGATES ACTION—Adopted the report of the Sixth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Fulton County Councilor

J. G. MCDANIEL, M.D., Atlanta

I have had a most active year as the Councilor from Fulton County—as you know, Council has been enlarged. All county medical societies now having more than 100 members have a Councilor and Vice Councilor of their own.

This year I have been present at all meetings of the Fulton County Medical Society—all meetings and called meetings of Council—and all meetings of the Executive Committee of Council which meets once monthly. I am a member of the Executive Committee by virtue of being appointed Chairman of the MAG Finance Committee. I am also pleased to report that I attended the AMA Annual Session in New York.

Fulton County had a good year—the Scientific programs were excellent and well attended.

As of January 1, 1962, we had 891 active members and 170 associate members—a total of 1061 members.

Charles Jones—our Vice Councilor, continues to do outstanding work. He is active on the Insurance and Economics Board. This Board is beset with seemingly never ending problems. It is a great comfort to have Dr. Jones work with me.

Counties and Secretaries	Members December 31, 1961		Members December 31, 1960	
	MAG	AMA	MAG	AMA
Fulton				
J. T. Anderson, Jr.				
Atlanta	947	724	917	730

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the report of the Fulton County Medical Society Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Fulton County Medical Society Councilor as recommended by the Reference Committee on motion duly made and seconded.

Bibb County Councilor

GEORGE H. ALEXANDER, M.D., *Forsyth*

Mr. Speaker and Members of the House of Delegates:

The Bibb County Medical Society has had a very successful year during 1961-62. At the business meeting held in December of 1961, the following officers were elected:

- President—William R. Birdsong
- President Elect—E. C. McMillan
- Vice President—Calder B. Clay, Jr.
- Secretary-Treasurer—John T. Dupree

George H. Alexander was nominated to the Medical Association of Georgia for a two-year term as Councilor.

Monthly meetings were held regularly with the exception of May 1961 which was omitted because of conflict of the meeting with the Medical Association of Georgia. In July the traditional picnic for the Society members and their wives was held as it is traditionally done in one of the summer months. Scientific programs were presented at all the other meetings. In December 1961, the Society was host to the Sixth District Medical Society Meeting.

The following is the record of membership as of December 31, 1960, and December 31, 1961:

Counties and Secretaries	Members December 31, 1961		Members December 31, 1960	
	MAG	AMA	MAG	AMA
Bibb				
John T. Dupree				
Macon	152	138	154	140

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the report of the Bibb County Medical Society Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Bibb County Medical Society Councilor as recommended by the Reference Committee by motion duly made and seconded.

Interprofessional Relations

J. G. McDANIEL, M.D., *Chairman*

This Board has been inactive for the reason that nothing has arisen to be brought before it.

Your Chairman attended a meeting of the Interprofessional Council which is composed of representatives from the medical, pharmaceutical and dental professions. At this meeting mutual problems of the professions were discussed.

We are pleased to report that the veterinarians are now members of the Interprofessional Council.

I believe that many good things could come from this Council. I am looking forward to its meeting in May.

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the report of the Interprofessional Relations Board and suggests further action regarding medical-legal liaison.

HOUSE OF DELEGATES ACTION—Adopted the report of the Interprofessional Relations Board as recommended by the Reference Committee on the additional recommendation of the Reference Committee on motion duly made and seconded.

Medical Education

J. W. CHAMBERS, M.D., *Chairman*

The Board of Medical Education, as probably most of the other Boards of this Association, has spent this year to a considerable extent attempting to organize its activities and of the various sub-committees assigned to it. Attached to this report you will find a report of the Sub-Committee on Medical Education; the Sub-Committee on AMEF and the Sub-Committee on Clarksville Laboratories. The Sub-Committee on Medical School Course headed by T. A. Sappington has been active in the early part of the year, was instrumental in setting up the course for the series of lectures to be presented to senior medical students on the art of the practice of medicine at the Medical College of Georgia and a copy of this series of lectures is attached for your information to this report. It is interesting to note that the course of lectures for this year's course was planned with several of the representative students from the senior class at the Medical College of Georgia being present at the planning session. T. A. Sappington, Chairman of this Sub-Committee, at the last meeting of the Board of Medical Education which was held on March 11, 1962, stated that he felt that this was a most important function of the medical education of the medical students and that this Sub-Committee should continue to be active and continue its attempt to get if possible sufficient interest manifested by medical schools other than the Medical College of Georgia, that is Emory Medical School, to also become interested in this series of lectures that have been so well received at the Medical College of Georgia.

One of the most important and this Board feels one of the most significant discussions which has been carried out during the meeting of the Board of Medical Education has been the idea of a conference to be sponsored by the Medical Association of Georgia on medical education for the state of Georgia and surrounding areas. This conference would probably serve as a most helpful means of beginning coordination of all medical education in this area, that is primarily involving the state of Georgia and the immediate surrounding area as well as helping to highlight some of the needs of medical education and the ways in which some of these needs possibly could be met. It seems to be the consensus of opinion of this Board that a coordinating mechanism for continuing medical education as well as for medical education in general is vitally needed and that this role could and should best be fulfilled by the Medical Association of Georgia. After full and complete discussion at its last meeting on March 11, on motion it was voted that this matter be presented to the House of Delegates for their approval. That is, that the Medical Association of Georgia sponsor a conference to be carefully planned by the Board of Medical Education on Medical Education for the State of Georgia and the surrounding areas sometime during the year between May 1962 and the end of that year of the Medical Association of Georgia. May I take this opportunity as Chairman of the Board of Medical Education during its first and organizational year to personally thank the members of the Board as well as the members of the various sub-committees who have served and given of their time in order to attempt to make this reorganizational year effective as well as productive of good for medical education in Georgia.

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves and commends the report of the Medical Education Board.

HOUSE OF DELEGATES ACTION—Adopted the report of the Medical Education Board as recommended by the Reference Committee on motion duly made and seconded.

AMEF Sub-Committee

W. DEVEREAUX JARRATT, M.D., *Chairman*

The Sub-Committee on AMEF met in Atlanta on November 12. This was a joint session.

The committee has studied the data from the American Medical Association and from MAG headquarters office, and we have encouraged individuals throughout Georgia to contribute moneys through this worthwhile organization to the medical schools. We, in particular, are interested in aiding Emory and the Medical College of Georgia.

I think that our efforts have been fruitful and we will continue in this endeavor throughout the coming year.

REFERENCE COMMITTEE RECOMMENDATIONS—This Committee accepts and approves the report of the AMEF Sub-Committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the American Medical Education Foundation Sub-Committee as recommended by the Reference Committee on motion duly made and seconded.

Medical School Course Sub-Committee

T. A. SAPPINGTON, M.D., *Chairman*

"THE ART OF THE PRACTICE OF MEDICINE"
1962 Course Schedule
Education Building
Medical College of Georgia

This series of lectures for senior medical students on the "Art of the Practice of Medicine" is co-sponsored and presented by the Medical Association of Georgia and the Medical College of Georgia and in conjunction with Mead Johnson & Company.

March 3 — 12:00 noon

"TYPES OF PRACTICE AND WHERE TO PRACTICE"

Joseph Mercer, M.D., Brunswick
Jule Neal, Jr., M.D., Macon

March 17 — 12:00 noon

"OPENING THE OFFICE AND LICENSURE"

Rafe Banks, M.D., Gainesville

March 31 — 12:00 noon

"ECONOMICS OF AN OFFICE PRACTICE"

J. Lee Walker, M.D., Nahunta

April 14 — 12:00 noon

"CONTINUING MEDICAL EDUCATION"

Walter Bloom, M.D., Atlanta

April 28 — 12:00 noon

"RELIGION AND MEDICINE"

Panel Presentation by a Minister (Protestant); a Priest (Catholic); and a Rabbi (Jewish)

May 11 — 4:00 p.m. — Richmond Hotel
(Wives Cordially Invited)

"M.D.'s PERSONAL ECONOMICS"

Mr. Virlyn Moore, Jr., Atlanta

5:00 p.m.

SENIOR DAY SOCIAL HOUR WITH BUFFET SUPPER AND ENTERTAINMENT

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts, approves and commends the report of this Medical School Course Sub-Committee. The Reference Committee takes note of the enthusiastic response and success of the course "The Art of the Practice of Medicine" given at the Medical College of Georgia and recommends that letters be sent from the President of the Medical Association of Georgia to the President of the Medical College of Georgia and to the President of the Senior Class of the Medical College of Georgia expressing appreciation for their cooperation.

The Reference Committee feels that this course is very valuable and hopes that the Sub-Committee will continue to seek cooperation and improvement of the same program at Emory University School of Medicine.

HOUSE OF DELEGATES ACTION—Adopted the report of the Medical School Course Sub-Committee as recommended by the Reference Committee with the additional recommendation of the Reference Committee on motion duly made and seconded.

Medical Education Sub-Committee

WALTER LYON BLOOM, M.D., *Chairman*

The sub-committee on medical education during the past year has been active in considering areas in which the Medical Association of Georgia can become more productive. The AMA Congress on Medical Education was attended by the Chairman of this committee in February and a report was presented to the Council on Medical Education. In this report it was pointed out that the independent physician and the independent hospital must be the cornerstone of internship, residency, and fellowship training as well as continuing education if the profession is to remain an independent profession and not a captive profession of institutional medicine.

The meeting on medical education was not too different than those in the past and it appeared that the presentation and people were concerned with broad generalities and few tangible facts emerged from the conference. There were no challenging new concepts presented and the old concepts were merely reiterated by entrenched professional educators. The only conclusion that one could derive from this meeting, as has frequently been true in the past, is that the group assembled was in favor of motherhood and against sin. These conferences are tangible evidence to indicate that more assumption of responsibility must be taken at the state level.

The activities of the committee on Medical Education will be expanded in the forthcoming year and it has been proposed that a conference on medical education be held on a statewide level in Georgia where emphasis may be placed on postgraduate and continuing education in the independent hospital with the community hospital as the logical center of the physician's activity in this regard.

Under discussion is development of a brochure to introduce high school students to the profession of medicine and to eliminate a number of the erroneous and

misleading concepts that frequently lead young people away from the profession. This information largely should come from the physicians of the state to the student.

Under consideration at the moment is a technique of student counseling at pre-medical level where physicians serve as the counselors rather than having paramedical educators deciding who should and who should not become a doctor. Certainly, emphasis must be placed on student counseling throughout the state by physicians who can tell students what is required and what the problems are of becoming and being a doctor. Certainly, many desirable students would not be led away from medicine as a career. A program of this nature has been in operation in LaGrange and has already proved its merit. In the near future a questionnaire will be sent to the doctors of this state asking their areas of special interest in which they can provide special skill or knowledge to their colleagues and a roster will be developed so that various medical societies, hospitals, and medical schools will have at their command a list of topics and people who can provide and participate in productive medical conferences.

With these undertakings in hand it would appear that the forthcoming year should be quite an active one in medical education in our state. It is imperative that the independent physician assume an increasing role in areas of medical education for which he has responsibility if we are going to keep the independence and high standards of American medicine which have made the quality of patient care an example for all the world.

REFERENCE COMMITTEE RECOMMENDATION—The Committee accepts, approves and commends the report of the Medical Education Sub-Committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the Medical Education Sub-Committee as recommended by the Reference Committee on motion duly made and seconded.

Clarkesville Lab Sub-Committee

BEN K. LOOPER, M.D., *Chairman*

Hammell Murray, a member of the committee, and I traveled to Clarkesville, Georgia, on Thursday, March 8 to inspect and evaluate the Medical Laboratory Assistants Training Course. This course is conducted by Mrs. Bowen, a medical laboratory technician. She is an excellent director, keeps the lab in tip-top condition; and is a member of ASCP. Mrs. Bowen's work is directed by an advisory committee from the Medical Association of Georgia. The training course is a one-year post high school pre-employment course designed to prepare the student for employment at entry levels in hospital laboratories, doctors' offices, and doctors' clinics.

Six months' intensive study is given in the school laboratory in the following classifications: professional ethics; medical terminology and spelling; keeping records and reports; elementary anatomy; physiology; care and maintenance of laboratory equipment; basic chemistry; urinalysis; blood chemistry; hematology; serology and blood banking; spinal fluid; bacteriology; feces study; electrocardiography, and preparation of specimen for mailing.

Upon completion the student is issued a record of training and certificate of completion. The school aids the student in finding a job. Applicants to the school

are accepted twice a year September 1 and March 1, and the classes consist of 15 members, so that special training may be concentrated upon each student. The school's standards are high, and at the present time the school has 17 students, two above the normal number, who are taking some additional bacteriology training.

Classes are for six hours a day five days a week for the first six months at the school; and eight hours a day five days a week while gaining laboratory experience in the hospital. The students are taking the following subjects:

1. Professional ethics
2. Terminology and medical spelling
3. Keeping records and reports
4. Care and maintenance of all types of laboratory equipment
5. Elementary anatomy and physiology
6. Basic chemistry to include working solutions
7. Urinalysis to include the following procedures:
 - (a) Albumin
 - (b) Sugar
 - (c) Microscopic
 - (d) Specific Gravity
 - (e) PH Determination
 - (f) Acetone
 - (g) Bile
 - (h) Urobilinogen
 - (i) Occult Blood
 - (j) Physical Characteristics of Urine Specimens
8. Blood chemistry to including the following tests:
 - (a) Sugar
 - (b) NPN and/or Bun
 - (c) Urea
 - (d) Bilirubin
 - (e) Icterus Index (Explain)
 - (f) Chlorides
 - (g) Co^{2+}
9. Hematology to include the following procedures:
 - (a) WBC
 - (b) RBC
 - (c) Hemoglobin
 - (d) Hematocrit
 - (e) Sed. Rates
 - (f) Bleeding and Clotting Time
 - (g) Blood Smears (basic, cellular Morphology which must be checked by doctor of medicine if a typical cell)
10. Prothrombin time (with caution)
11. Serology and blood banking
 - (a) Typing, RH, and cross matches (must be checked by a doctor of medicine) and Coombs Tests to include the minimum safe procedures recommended by the American Blood Banking Association.
 - (b) VDRL
12. Preparation of specimen for mailing to larger laboratories to include:
 - Pathological tissues and cytological preparations (fixatives)
13. Spinal fluids to include the following:
 - (a) Cell Count
 - (b) Sugar
 - (c) Pandy

(d) Physical Characteristics and Specific Gravity of Fluid

(e) Colloidal Gold

14. Bacteriology, to include the preparation of smears and the staining thereof with Grams Stain, preparation of cultures, collection of blood cultures and also the preparation of materials for mailing to larger laboratories for further bacteriological studies. (T.B. smears checked by a doctor of medicine should know how to perform coagulase test for staphylococcus).

15. Feces studies to include:

(a) Occult Blood

(b) Preparation of Smears and Other Material for Mailing to Larger Laboratories

16. Gastric analysis, tubeless type (diagnex)

17. EKG or electrocardiography

Dr. Murray and I were very much impressed with the progress being made, and the fact that the students were from the upper one-third of their high school classes. The students were neat, and hard at work when we visited the lab.

REFERENCE COMMITTEE RECOMMENDATION—The Committee accepts and approves the report of the Clarkesville Laboratory Sub-Committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the Clarkesville Laboratory Sub-Committee as recommended by the Reference Committee on motion duly made and seconded.

Special Activities

JOHN S. ATWATER, M.D., *Chairman*

The Board of Special Activities has, as one of its main functions, the duties and responsibilities of the Sub-Committee on Health Care of the Aging. As I also serve in the capacity as Chairman of that Sub-Committee, my report on this matter is given below.

Another activity referred to the Board by MAG House of Delegates, was that of the MAG Physician's Placement Bureau. Every three months a new listing of "locations seeking physicians" is compiled and made available to doctors desiring to practice in Georgia. A similar list of "physicians seeking locations" is made available to communities wishing to have a physician practice in such city or town. The data for these listings is compiled from questionnaires filled out by physicians and locations. Liaison with the State Board of Medical Education is maintained to advise this Board about the placement of "loan fund" physicians under the program of the State Board. The American Medical Association also provides information for our "physician seeking location" lists. We plan to improve this service to better effect the placement of physicians in certain target areas over the state that need a practitioner.

I wish to assure the House of Delegates that our Board stands ready to cooperate on any projects or activities referred to the Board by the House, Council or its Executive Committee and I wish to thank the members of the Board for their cooperation during the Association year 1961-62.

REFERENCE COMMITTEE RECOMMENDATION—The Committee accepts, approves and commends the report of the Special Activities Board.

HOUSE OF DELEGATES ACTION—Adopted the report of the Special Activities Board as recommended by the Reference Committee on motion duly made and seconded.

Health Care of Aging Sub-Committee

JOHN S. ATWATER, M.D., *Chairman*

This Committee has continued its activities much as reported to the Medical Association of Georgia last year. There has been continued support of the Kerr-Mills law and continued effort to block the King-Ander-son Bills. This has been accomplished through many media, the most important being through cooperation with the Governor's Commission on Aging and the Georgia Joint Council to Improve the Health Care of the Aged. Numerous appearances have been made before civic and professional groups as well as through the radio and television media. Printed news outlets have also been utilized.

The Committee has been represented at (1) the National Joint Council to Improve the Health Care of the Aged (Chicago, Ill.), (2) the Regional White House Conference on Aging (Nashville, Tenn.), (3) one member has acted as moderator for the Regional Conference on Aging (Charlotte, N. C.) sponsored by the American Medical Association, and (4) one member continues to serve as Consultant to the Committee on Aging, Council on Medical Services, American Medical Association.

It is hoped that every physician in Georgia is aware of the threat of social legislation and its effect on lowering the quality of medical care.

In view of the continuing fight it is recommended that the Medical Association of Georgia continue its support of this work.

REFERENCE COMMITTEE RECOMMENDATION—The Committee accepts and approves the report of the Health Care of the Aging Sub-Committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the Health Care of the Aging Sub-Committee as recommended by the Reference Committee on motion duly made and seconded.

It was moved by Vice-Chairman of Reference Committee No. 5, C. S. Britt, Brunswick and duly seconded that the report of Reference Committee No. 5 be approved as a whole and it was so ordered.

Speaker Walker then called for unfinished business and there being none, Dr. Walker opened the floor for new business. There being no new business, Speaker Walker entertained a motion for adjournment of the Second Session of the Medical Association of Georgia House of Delegates Meeting in conjunction with the 108th Annual Session of the Association. On motion duly made and seconded, the House adjourned at 11:00 A.M.

GENERAL BUSINESS SESSION

108th ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

SUNDAY, MAY 6, 1962

THE FIRST GENERAL BUSINESS SESSION of the 108th Annual Session of the Medical Association of Georgia was called to order by President Fred Simonton, Chickamauga at 2:05 P.M. in the DeSoto Ballroom, DeSoto Hotel, Savannah, Georgia on May 6, 1962.

President Simonton stated the purpose of this first General Business Session was the nomination of officers, councilors, and nominations for certain MAG awards. Dr. Simonton then appointed a Tellers Committee as follows: Milford B. Hatcher, Macon, Chairman; John Tate, Rome, Member; and J. G. McDaniel, Atlanta, Member. Dr. Simonton announced that the hours for balloting on these nominations were as follows: May 6—2:30 P.M. to 5:00 P.M.; May 7—9:00 A.M. to 12:00 NOON; May 8—9:00 A.M. to 5:00 P.M., at which time the ballot box would officially close.

President Simonton then called for nominations from the floor for Association officers and the following nominations were made:

Nominations

President-Elect—George Dillinger, Thomasville; nominated by W. P. Rhyne, Albany; seconded by Charles Andrews, Canton and Joseph Mercer, Brunswick.

There being no other nominations for the office of President-Elect, President Simonton instructed the Secretary to cast a unanimous ballot for George Dillinger as President-Elect of the Medical Association of Georgia.

Second Vice President—Walker Curtis, College Park; nominated by Hugh Hailey, Atlanta; seconded by John Atwater, Atlanta and John W. Turner, Atlanta.

There being no further nominations, President Simonton instructed the Secretary to cast a unanimous ballot for Walker Curtis, College Park as Second Vice President of the Association.

AMA Delegate (term beginning January 1, 1963)—Henry Tift, Macon; nominated by David R. Thomas, Augusta; seconded by Frank Eldridge, Valdosta.

There being no other nominations, President Simonton instructed the Secretary to cast a unanimous ballot for the election of Henry Tift, Macon, as AMA Delegate.

AMA Alternate Delegate (term beginning January 1, 1963)—Preston Ellington, Augusta; nominated by David R. Thomas, Augusta; seconded by T. A. Sappington, Thomaston.

There being no other nominations, President Simonton instructed the Secretary to cast a unani-

mous ballot to elect Preston Ellington, Augusta, as AMA Alternate Delegate.

AMA Delegate (term beginning January 1, 1963)—Eustace Allen, Atlanta; nominated by Walter Brown, Savannah; seconded by Hugh Hailey, Atlanta; Frank McKemie, Albany; Henry Tift, Macon; and J. W. Chambers, LaGrange.

There being no other nominations, President Simonton instructed the Secretary to cast a unanimous ballot for the election of Eustace A. Allen, Atlanta as AMA Delegate.

AMA Alternate Delegate (term beginning January 1, 1963)—J. Frank Walker, Atlanta; nominated by Linton Bishop, Atlanta; seconded by William Coles, Atlanta; Joseph Mercer, Brunswick; and W. A. Wilkes, Augusta.

There being no other nominations, President Simonton instructed the Secretary to cast a unanimous ballot for the election of J. Frank Walker, Atlanta, as AMA Alternate Delegate.

President Simonton then referred to Chapter V, Section 2 of the MAG Constitution and Bylaws as follows: "Nominations for Councilor and Vice Councilor shall be made by each District Society at its annual meeting and forwarded by its Secretary to the Secretary of the Association not later than 15 days before the Annual Session. If no nomination is presented by District Society in this matter, nomination shall be made from the floor. Nominations for the County Medical Societies having 100 or more active members which are entitled to elect one Councilor and one Vice-Councilor directly representing that Society shall be forwarded in like manner as a District Society for the election by ballot by the members of the Association during the Annual Session."

President Simonton then read the nominations as received at least 15 days prior to the convening of this Annual Session from the Fifth District; Sixth District; Seventh District; Eighth District; and the Muscogee County Medical Society.

Fifth District Councilor (1965)—Floyd Sanders, Decatur.
Sixth District Councilor (1965)—William Rawlings, Sandersville.

Sixth District Vice Councilor (1965)—John Bell, Dublin.
Seventh District Councilor (1965)—Ralph Johnson, Rome.

Seventh District Vice-Councilor (1965)—William Mitchell, Smyrna.

Eighth District Councilor (1965)—Frank Eldridge, Valdosta.

Eight District Vice Councilor (1965)—J. W. Yeomans, Jesup.

Muscogee County Medical Society Councilor (1965)—W. P. Jordan, Columbus.

Muscogee County Medical Society Vice Councilor (1965)
—Luther Wolff, Columbus.

President Simonton announced that there was one more Councilor and Vice Councilor nomination received by the Association as necessitated by the resignation of the present Councilor of the Second District Medical Society. Dr. Simonton stated that he had been informed by letter by the Secretary of the Second District Medical Society that at the Semi-Annual Meeting of that Society, Dr. George Dillinger, Councilor from the Second District, resigned effective May 5, 1962. Therefore, at that time, the Second District forwarded to the Association the following nomination to fill the unexpired term of Dr. Dillinger:

Second District Councilor (1964)—Frank McKemie, Albany.

Second District Vice Councilor (1964)—J. C. Brim, Pelham.

President Simonton then stated under the authority of the Constitution and Bylaws, he would instruct the MAG Secretary to cast a ballot in behalf of the membership for these unopposed nominations as presented by their respective District and County Medical Societies and thereby declare these nominees so elected.

At this time, President Simonton then stated that there were no contested offices and that the Tellers Committee need not conduct general balloting for Association Officers.

GP of the Year Award

President Simonton called for nominations for the "General Practitioner of the Year Award." The following nominations were made:

K. W. Milligan, Augusta; nominated by Walter Sheppard, Augusta; seconded by Milford Hatcher, Macon.

W. P. Ezzard, Lawrenceville; nominated by J. W. Mauldin, Lawrenceville; seconded by Henry Tift, Macon and Charles Andrews, Canton.

On motion duly made and seconded it was moved that the nominations be closed and President Simonton informed the membership that these nominations will be presented to the MAG House of Delegates and from these nominations the House of Delegates would elect the GP of the Year Award recipient.

Hardman Award

President Simonton called for nominations for the Hardman Award and the following nomination was received:

Rudolph Bartholomew, Atlanta, nominated by J. G. McDaniel, Atlanta; seconded by Charles Cowart, LaGrange.

There being no further nominations, President Simonton informed the general membership that this nomination would be considered and voted on by the House of Delegates.

There being no further business, the first General Business Session of the 108th Annual Session of the Medical Association of Georgia was recessed at 2:45 P.M.

GENERAL BUSINESS SESSION (Second Session)

108th ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

MONDAY, MAY 7, 1962

THE SECOND GENERAL BUSINESS SESSION of the 108th Annual Session of the Medical Association of Georgia was called to order by President Fred Simonton, Chickamauga at 12:05 P.M. in the DeSoto Ballroom, DeSoto Hotel, Savannah, Georgia on Monday, May 7, 1962.

The invocation was given by the Rev. Ernest Risley, St. John's Episcopal Church, Savannah, Georgia.

A word of welcome was given by John Kirk Train, Jr., Savannah, President of the Georgia Medical Society, in behalf of the membership of the Society who were hosts for this 108th Annual Session.

The Honorable Malcolm Maclean, Mayor, City of Savannah, welcomed the Medical Association of Georgia membership and their wives and

guests to Savannah on the occasion of this meeting.

President Simonton then turned the gavel over to First Vice President Linton H. Bishop, Atlanta, who then presided. Dr. Bishop introduced President Fred Simonton to address the membership on the subject: "Report of the Presidential Year, 1961-1962." On completion of the President's speech, Dr. Simonton again assumed the duties of presiding officer.

President Simonton introduced President-Elect Thomas Goodwin, who presented an address to the Association membership on the subject: "Our Association Future for 1962-1963."

Upon completion of the address by President-Elect Thomas Goodwin, President Simonton recessed the second General Business Session of the 108th Annual Session of the Medical Association of Georgia at 12:55 P.M.

blood pressure approaches normal more readily, more safely....simply with **Salutensin**[®] (hydroflumethiazide, reserpine, protoveratrine A—antihypertensive formulation)

Early, efficient reduction of blood pressure. Only Salutensin combines the advantages of protoveratrine A ("the most physiologic, hemodynamic reversal of hypertension"¹) with the basic benefits of thiazide-rauwolfia therapy. The potentiating/additive effects of these agents²⁻⁸ provide increased antihypertensive control at dosage levels which reduce the incidence and severity of unwanted effects.

Salutensin combines Saluron[®] (hydroflumethiazide), a more effective 'dry weight' diuretic which produces up to 60% greater excretion of sodium than does chlorothiazide⁹; reserpine, to block excessive pressor responses and relieve anxiety; and protoveratrine A, which relieves arteriolar constriction and reduces peripheral resistance through its action on the blood pressure reflex receptors in the carotid sinus.

Added advantages for long-term or difficult patients. Salutensin will reduce blood pressure (both systolic and diastolic) to normal or near-normal levels, and maintain it there, in the great majority of cases. Patients on thiazide/rauwolfia therapy often experience further improvement when transferred to Salutensin. Further, therapy with Salutensin is both economical and convenient.

Each Salutensin tablet contains: 50 mg. Saluron[®] (hydroflumethiazide), 0.125 mg. reserpine, and 0.2 mg. protoveratrine A. See Official Package Circular for complete information on dosage, side effects and precautions.

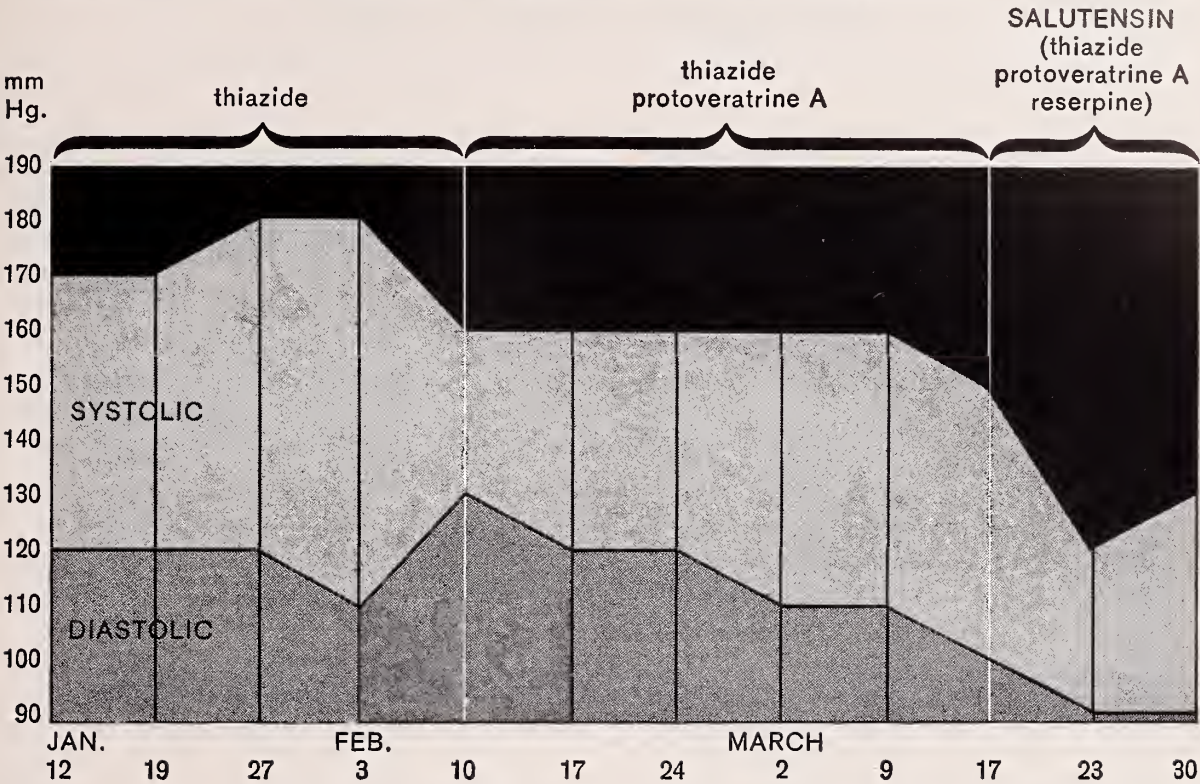
Supplied: Bottles of 60 scored tablets.

References: 1. Fries, E. D.: In Hypertension, ed. by J. H. Moyer, Saunders, Phila., 1959 p. 123. 2. Fries, E. D.: South M. J. 51:1281 (Oct.) 1958. 3. Finnerty, F. A. and Buchholz, J. H.: GP 17:95 (Feb.) 1958. 4. Gill, R. J., et al.: Am. Pract. & Digest Treat. 11:1007 (Dec.) 1960. 5. Brest, A. N. and Moyer, J. H.: J. South Carolina M. A. 56:171 (May) 1960. 6. Wilkins R. W.: Postgrad. Med. 26:59 (July) 1959. 7. Gifford, R. W., Jr.: Read at the Hahnemann Symp. on Hypertension, Phila. Dec. 8 to 13, 1958. 8. Fries, E. D., et al.: J. A. M. A. 166:137 (Jan. 11) 1958. 9. Ford, R. V. and Nickell, J.: Ant. Med. & Clin. Ther. 6:461, 1959.

all the antihypertensive benefits of thiazide-rauwolfia therapy plus the specific, physiologic vasodilation of protoveratrine A

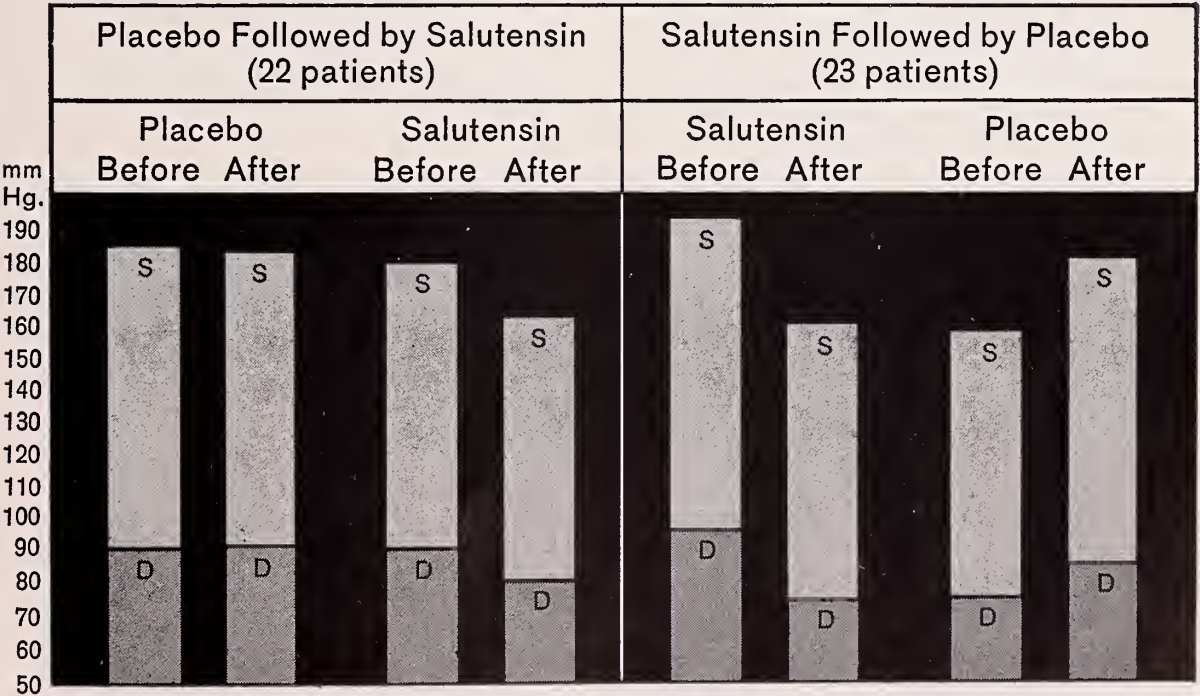
11 WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS BY SERIAL ADDITION OF THE INGREDIENTS IN SALUTENSIN IN A TEST CASE

(Adapted from Spiotta, E. J.: Report to Department of Clinical Investigation, Bristol Laboratories)



3½ WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS USING SALUTENSIN FROM THE START OF THERAPY IN A "DOUBLE BLIND" CROSSOVER STUDY

Mean Blood Pressures—Systolic (S) and Diastolic (D)



In this "double blind" crossover study of 45 patients, the mean systolic and diastolic blood pressures were essentially unchanged or rose during placebo administration, and decreased markedly during the 25 days of Salutensin therapy. (Smith, C. W.: Report to Department of Clinical Investigation, Bristol Laboratories.)



GENERAL BUSINESS SESSION (Third Session)

108th ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

WEDNESDAY, MAY 9, 1962

THE THIRD GENERAL BUSINESS SESSION of the 108th Annual Session of the Medical Association of Georgia was called to order by President Fred Simonton, Chickamauga, at 11:05 A.M. in the DeSoto Ballroom, DeSoto Hotel, Savannah, Georgia on Wednesday, May 9, 1962.

Fifty-Year Certificates

President Simonton called on Immediate Past-President Milford Hatcher, Macon, who presented the Fifty-Year Certificates and Pins to physician members who have practiced medicine for 50 years or more. These presentations were made to the following physicians: Homer Lumpkin Barker, Carrollton; James Gordon Brantley, Wrightsville; Ben Hill Clifton, Atlanta; Grover Cleveland Cole, Dallas; Albert Nathan Dykes, Columbus; Clifford Clay Elliott, Sargent (deceased); Bernard Lamar Helton, Sandersville; Henry Woodfine Minor, Atlanta; James L. Morris, Alpharetta; Frank C. Nesbit, Covington; Emory Robert Park, LaGrange; James Roscoe Sams, Covington; Egbert M. Townsend, Ringgold; Guy O. Whelchel, Athens; and James H. Whiteside, Statesboro (deceased).

Scientific Exhibits Awards

President Simonton called on Edgar Grady, Atlanta, Chairman of the Association's Scientific Exhibit Awards Committee, who made the following presentations:

First Place Award—"Enzymatic Defects in the Ovaries of Hirsute Women"—

Robert B. Greenblatt, M.D.; Virendra B. Mahesh, Ph.D., and Cetin K. Aydar, M.D., Augusta.

Second Place Award—"Temporograms"—

David T. Smiley, M.D. and Lester A. Brown, M.D., Atlanta.

Third Place Award—"Progress in Pulmonary Angiography"—

W. D. Logan, Jr., M.D.; O. A. Abbott, M.D.; B. B. Gay, M.D., and James V. Rogers, M.D., Atlanta.

GP of the Year Award

President Simonton called on Charles McArthur, Cordele, President of the Georgia Academy of General Practice, to present the GP of the Year Award. Dr. McArthur presented the "General Practitioner of the Year Award" to King Milligan, Augusta.

Certificates of Appreciation

President Simonton requested John T. Mauldin, Atlanta, Secretary of the Medical Association of

Georgia, to present the following Certificates of Appreciation. Dr. Mauldin then presented these Certificates of Appreciation in behalf of MAG: Fred Simonton, Chickamauga, awarded for service as President of the Medical Association of Georgia, 1961-62; Mrs. A. Worth Hobby, Atlanta, awarded for service as President of the Woman's Auxiliary of the Medical Association of Georgia, 1961-62; C. Raymond Arp, Atlanta, posthumously awarded for service as Treasurer of the Medical Association of Georgia; Linton Bishop, Atlanta, awarded for service to the Association as Vice President, 1961-62; Henry Tift, Macon, awarded for service to the Association as Chairman of the MAG Annual Session Committee, 1957-1961; George R. Dillinger, Thomasville, awarded for service to the Association as Second District Councilor, 1952-1962; Ralph Fowler, Marietta, awarded for service to the Association as Seventh District Councilor, 1959-1962; James Hicks, Brunswick, awarded for service to the Association as Eighth District Vice Councilor.

At this time, President Simonton called on Drs. David R. Thomas, Augusta, Chairman of the MAG Insurance and Economics Board and Dr. John Elliott, Savannah, to present a special Certificate of Appreciation to Mr. H. B. Coolidge, Savannah, for his outstanding assistance to the Insurance and Economics Board of MAG. Accompanying this Certificate of Appreciation was a small gift from the Association to mark this occasion.

President Simonton then presented a Certificate of Appreciation to John T. Mauldin, Atlanta for his service to the Association in the field of Health Care of the Aged.

Hardman Award

President Simonton called on President-Elect Thomas Goodwin, Augusta, to present the Hardman Award Certificate and Cup. President-Elect Goodwin presented the Hardman Award Certificate and Cup to Rudolph Bartholomew, Atlanta.

Site of 1964 Annual Session

President Simonton announced that the site for the 1963 Annual Session has been previously set as Jekyll Island on the invitation of the Glenn County Medical Society. He called for invitation to MAG to convene the 1964 Annual Session. Milford

Hatcher, in behalf of the Bibb County Medical Society in Macon, invited the Association to hold its 1964 meeting in Macon and the invitation was so accepted.

Election Results

President Simonton stated that as none of the elected Officers of the Association were contested, and as he had instructed the Secretary of the Association to cast a unanimous ballot electing those nominees made at the first General Business Session held May 6, 1961, that the Tellers Committee reported that this had been done, and accordingly these nominees so elected.

Official Attendance Records

President Simonton announced that compilation of the official attendance at the 108th Annual Session of the Medical Association of Georgia was as follows: MAG members—686; other physicians registered—74; Association guests—69; and exhibitors registered—138, making a grand total of 967 registrants.

Installation of Officers

The next order of business was the installation of the 1962-63 Officers and Councilors as follows:

President—Thomas Goodwin, Augusta (1963).

President-Elect—George Dillinger, Thomasville (1963).

Immediate Past President—Fred Simonton, Chickamauga (1963).

First Vice President—Lee Battle, Rome (1963).

Second Vice President—Walker Curtis, College Park (1963).

Speaker of the House—J. Frank Walker, Atlanta (1965).

Vice Speaker of the House—Joseph Mercer, Brunswick (1965).

AMA Delegate (term beginning January 1, 1963)—Henry Tift, Macon (December 30, 1965).

AMA Alternate Delegate (term beginning January 1, 1963)—Preston Ellington, Augusta (December 30, 1965).

AMA Delegate (term beginning January 1, 1963)—Eustace A. Allen, Atlanta (December 30, 1965).

AMA Alternate Delegate (term beginning January 1, 1962)—J. Frank Walker, Atlanta (December 30, 1965).

Second District Councilor—Frank McKemie, Albany (1964).

Second District Vice Councilor—J. C. Brim, Pelham (1964).

Fifth District Councilor—Floyd Sanders, Decatur (1965).

Fifth District Vice Councilor—Lawrence Mathews, Decatur (1965).

Sixth District Councilor—William Rawlings, Sandersville (1965).

Sixth District Vice Councilor—John Bell, Dublin (1965).

Seventh District Councilor—Ralph Johnson, Rome (1965).

Seventh District Vice Councilor—William Mitchell, Smyrna (1965).

Eighth District Councilor—Frank Eldridge, Valdosta (1965).

Eighth District Vice Councilor—J. W. Yeomans, Jesup (1965).

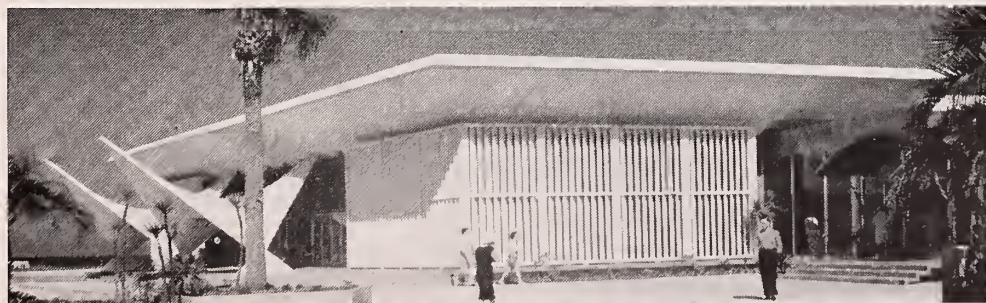
Muscogee County Medical Society Councilor—W. P. Jordan, Columbus (1965).

Muscogee County Medical Society Vice Councilor—Luther Wolff, Columbus (1965).

Immediate Past President Fred Simonton then turned the gavel over to President Thomas Goodwin.

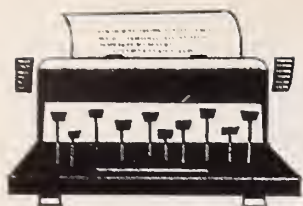
There being no further business, President Goodwin adjourned the 108th Annual Session of the Medical Association of Georgia held at the DeSoto Hotel, Savannah, Georgia, May 6-9, 1962 at 12:05 P.M.

Plan now to attend the 109th Annual Session of the MEDICAL ASSOCIATION OF GEORGIA May 5-8, 1963 Jekyll Island, Georgia



Meetings — AQUARAMA

Headquarters — BUCCANEER MOTEL



The Annual Convention, Savannah, 1962

AS HAS LONG been the custom, this issue of the *Journal* is devoted entirely to matters related to the Annual Session of the Medical Association of Georgia. This year's gathering in Savannah, May 6 through May 9, marked the 108th annual meeting of the Association.

While much useful, current, scientific knowledge was disseminated by scores of outstanding speakers, perhaps the single item evoking the most widespread interest was the recommendation by the MAG Insurance and Economics Board to the House of Delegates for the acceptance of a senior citizens program sponsored by the National Blue Shield Plan. The plan proposes to pay for physician care for the aged of limited means on a fixed fee service basis rather than on an indemnity basis as a part of its hospital coverage program. This plan would cover those citizens 65 years of age and over with an annual income up to \$4,000 per couple. About one-fifth of the premium would go for professional fees and four-fifths for hospitalization. The program has the approval of the Board of Trustees of the American Medical Association.

As evidence of the widespread interest in this program both pro and con it is noteworthy that this issue was discussed in the Reference Committee for six hours before a decision was reached. The decision was to accept the recommendation of the Insurance Committee that the program be endorsed by the House of Delegates.

During the testimony and discussions it was apparent that both the advocates and opponents of the program were hampered by a lack of concise details surrounding the proposed plan. One of the primary objections voiced by many was the fee

for service feature for fixing medical fees. In spite of these obvious drawbacks it was stimulating to witness the spirited open forum during which all points of view were aired in serious discussion. Another question raised was national versus local administration of such a plan. Diverse opinions from many areas of medical practice were heard. With all the diversity of opinion expressed, most came away from these hearings with the feeling that here was the democratic process in action—here was one of the many justifications for our Association.

At the meeting of the House of Delegates the largest representation in recent years was counted. After preliminary discussion from the floor, it became apparent that much needed information was not available. For this and other reasons a motion was made to table the recommendation of the Reference Committee regarding approval of the Blue Shield Plan. This motion was passed by a small majority. The Council of the Medical Association of Georgia may now study the Blue Shield Plan further as its details of administration become more clearly defined. At such time the Council will then be empowered to act for the MAG in endorsing or rejecting the proposed plan. Whatever the final outcome of the MAG decision it should be understood that this will in no way bind or limit the individual physician from participating in whatever plan he sees fit.

As centralized agencies and our federal government become more involved in the private practice of medicine, it is heartening to see the doctors of Georgia giving careful consideration before accepting fundamental changes in our approach to patient care.

Diastolic Rumbles

MOST CLINICIANS APPRECIATE the fact that mitral stenosis due to rheumatic heart disease is associated with a diastolic rumble heard at the apex of the heart. This auscultatory phenomenon is not easy to learn. It is the rare individual who can be absolutely

certain of his diagnosis of previously unrecognized mitral stenosis, prior to his internship or first year of resident training. A diastolic rumble will not be heard unless the observer listens specifically for it. It is necessary to use the bell of the stethoscope. The

bell should be applied to the skin at the cardiac apex impulse with very light pressure. The rumble is usually heard best where the apex impulse is felt and may be localized to a very small area, frequently no larger than a 25-cent piece. It is useful to have the patient exercise and assume the left lateral recumbent position in order to accentuate the auscultatory findings. There are six auscultatory features of mitral stenosis that should be sought. The first heart sound is usually loud, sharp and short. The opening snap of the mitral valve is heard just after the second sound, farther out than a split and closer to the second sound than a ventricular gallop. The opening snap is more high-pitched than a gallop sound. It is necessary to learn to judge the time interval between the second sound and the opening snap, for if the interval is short, it is statistically likely that the mitral stenosis is severe. The low-pitched diastolic rumbling murmur follows the opening snap, may then fade a bit and then becomes louder toward the end of diastole, being greatly accentuated just prior to the first sound as a result of atrial contraction. This pre-systolic accentuation is eliminated when atrial fibrillation is present. The pulmonic component of the second heart sound may be loud when there is pulmonary hypertension and pulmonary regurgitation may occur. After much earnest effort, one learns to hear the features of mitral stenosis just described. He then may feel content with the knowledge that most patients with mitral stenosis due to rheumatic heart disease have diastolic rumbles, and that he has now learned to hear such rumbles. Life becomes somewhat more complex when one learns that there are many causes of diastolic rumbles at the apex and that all that rumbles is not mitral stenosis. The purpose of this communication is to point out some of the other causes of diastolic rumbles at the apex. Space does not allow detailed discussion of the mechanisms responsible for such murmurs.

1. Patent ductus arteriosus is associated with a larger than normal volume of blood entering the left atrium. This large volume of blood must pass a relatively normal size mitral valve and a diastolic rumble may be produced. The first heart sound is not usually loud and the opening snap is not heard.

2. Interventricular septal defect is associated with a larger than normal volume of blood entering the left atrium. This large volume of blood passes through a relatively normal size mitral valve and a diastolic rumble is produced. The first heart sound is not usually loud and the opening snap is not usually heard.

3. Atrial septal defect frequently is associated

with a diastolic rumble located somewhere near the cardiac apex. In this case an extremely large volume of blood enters the right atrium and passes through a relatively normal size tricuspid valve. It is likely that this rumble emanates from the tricuspid area. The first heart sound is not usually loud and the opening snap is not heard.

4. Moderately severe aortic regurgitation may be associated with a diastolic rumble at the apex. The mechanism for this is quite complex. One feature seems to be that the regurgitated column of blood depresses the anterior leaflet of the mitral valve. This impedes blood flow across the mitral valve and a diastolic rumble is produced. This rumble was first described by Austin Flint.

5. Moderately severe anemia may be associated with a diastolic rumble at the apex, along with other hemic murmurs. Anemia due to sickle cell disease may produce congestive heart failure and murmurs, including a diastolic rumble. Heart failure and murmurs occur at a higher hemoglobin level in sickle cell anemia than in iron deficiency. This seems to be because sickle cell disease is associated with thrombi in many vessels, including the small arteries in the heart, and because the oxygen disassociation curve is abnormal when there is sickle cell disease.

6. Severe mitral regurgitation may, on occasion, produce considerable confusion. When there is moderate mitral regurgitation, then the volume of blood in the left atrium is larger than normal; and as it passes through the mitral valve a diastolic rumble may be produced. This is a flow rumble that is in no sense different from the flow rumble heard in left-to-right shunts. Real confusion is created occasionally when there is severe mitral regurgitation without a systolic murmur and when a flow rumble is present. Then, to add to the confusion, an opening snap can occasionally be heard under these circumstances and the auscultatory findings of mitral stenosis become almost complete. Under these circumstances the separation of mitral stenosis and mitral regurgitation is usually made by considering the type of apex impulse, the findings in electrocardiogram, and at cardiac fluoroscopy. With all this it is not possible to be accurate at all times. One is not justified in further procedures unless the patient has signs and symptoms indicating that if an operable disease could be identified, surgery would be beneficial. If this is the case, this may lead one to subject a patient to left heart catheterization and angiocardiology. Even these procedures do not always clarify the issue.

7. The myocarditis resulting from acute rheumatic fever may be associated with a diastolic rumble at the cardiac apex. This rumble, along with other

murmurs, is presumably due to cardiac dilatation, rapid blood flow and edema of the valves themselves. Marked cardiac dilatation due to any cause may be associated with a diastolic rumble at the apex.

8. Left atrial tumor may be associated with a diastolic rumble at the apex. An opening snap at the mitral valve may also be heard. It is likely that the tumor in some way stretches, or otherwise alters, the anterior leaflet of the mitral valve sufficiently to produce an opening snap. The diastolic rumble due to left atrial tumor may occasionally be heard best with the patient sitting rather than the left lateral

recumbent position. The rumble may be heard one day and not heard the next.

In summary, the diastolic rumble resulting from mitral stenosis secondary to rheumatic heart disease is difficult to hear and may be overlooked unless the clinician is quite careful. After learning to hear this rumble, one cannot rest comfortably with the notion that all rumbles are due to mitral stenosis. Because of this, I have pointed out eight additional causes of diastolic rumbles. To be sure they do not have all of the features of mitral stenosis, but are similar enough to create confusion.

Georgia Doctors Form Political Action Committee

A NEW ENTITY ON THE Georgia political scene has emerged as the result of a meeting of physicians held in Savannah during the recently concluded 108th Annual Session.

Responding to a growing awareness of all professional people to participate more actively and more directly in political and governmental affairs, the doctors of Georgia met to form a new group known as the Georgia Medical Political Action Committee, or GaMPAC for short.

GaMPAC Membership

GaMPAC is a voluntary, non-profit, unincorporated group whose membership is open to physicians, their wives, members of their families and others of like mind and political inclination.

Federal law prohibits direct political participation by a corporation. For this reason GaMPAC was organized separate and apart from the Medical Association of Georgia and there is no relationship between the two other than the fact that MAG heartily endorses this new political group.

At an organizational breakfast meeting held on May 8th, Milford Hatcher of Macon was selected to serve as Chairman of GaMPAC. Mrs. John L. Elliott, wife of Dr. Elliott was selected to serve in the capacity of Co-Chairman, and another Savannah, William W. Osborne was selected to act as Secretary-Treasurer.

Need for GaMPAC

The need for a medical-political organization—a political action group as opposed to a legislative group—has been apparent to many people associated with organized medicine for a good long time. The old saying that medicine and politics do not mix is no longer valid and indeed has been invalid for many years. Realization by doctors that they have a civic obligation equal to their professional obliga-

tion provided the impetus for the creation of this political action committee.

The primary goal of GaMPAC is good government. Distilled to its essence this means that the Georgia Medical Political Action Committee will be primarily concerned with the election of public officials who in the estimation of the Committee will do the best job of providing the best possible government for all the citizens including medical practitioners. GaMPAC was not as some will suspect, organized merely to oppose the Administration's program of medical aid for the aged through Social Security.

To achieve its goal of good government the Committee has assumed a dual role. First, it will help its members understand political issues in both the medical and non-medical field. It plans to publish voting records, analyses of legislative matters and related materials designed to give the members of GaMPAC a better and more thorough understanding of the matters and the personalities on the political scene in Georgia.

GaMPAC Objective

Since good government is GaMPAC's over riding objective it will not concern itself with any political party per se. Rather it will attempt to assess the true value of all major candidates for responsible public office and pass this assessment on to its members. These functions will comprise, in large measure, the educational role which GaMPAC will play.

A second role and perhaps the most important of the two will be in assisting members to organize for effective political action. This will be achieved through the pooling of material resources in favor of those candidates for public office whose past records indicate philosophical and practical alignment with the membership of GaMPAC. It is this aspect of GaMPAC which more than any other distinguishes it as a political action group.

Membership in the Committee, as previously stated, is open to physicians, their families and others. Membership dues have been set at \$25 per person. Thus at what is actually a nominal fee, doctors may be able to have the greatest possible effect on the outcome of elections with the consequent assurance that only good men are elected to high office in Georgia both at the state and national level.

Plato is credited with having said that the price one pays for being politically inactive is that he

is governed by his inferiors. The role of government has so expanded in recent years that this statement takes on added importance. There can be no honest denial by any enlightened person that physicians and other professional people have an obligation to become active in the affairs of our government. If we choose not to do so we abdicate in favor of our inferiors.

MAG congratulates those physicians who have taken the lead in the formation of GaMPAC. The need for such a group is clear and the Medical Association commends it to its entire membership with the high hope that every MAG member will become actively affiliated with GaMPAC.

A CRACK IN A SOCIALIST ILLUSION

Every poll that has ever been taken in Britain shows that the majority of people there are in favor of their socialized medical program where all is "free" and no man need worry about a doctor's bill.

So if popularity is the test, it has been a political success. But now there is beginning to appear an ominous crack in the happy illusion that the British have, by socializing their medicine, thereby banished their medical cares. Doctors' bills have vanished. Now the doctors are vanishing too.

The fact of a dwindling supply of British doctors in Britain is now unquestioned; it has been the subject of worried discussion in economic and medical journals, in magazines and newspapers and in Parliament. The article we publish from the British Medical Journal is typical of some of the wide-spread concern.

Briefly, here is what has happened:

In the early years of the National Health Service young British students entered the medical schools in their accustomed number and some of the schools even showed an increase in total enrollment. The figures on the licensing of new doctors in Britain also were increasing. All seemed to be well, and in 1957 the government planners were even urging an immediate reduction in the number of medical students.

Suddenly everybody woke up to the fact that British medical students weren't converting themselves into British doctors. Increasing numbers of them were going off to Canada, Australia, America and other backward places where a doctor is not in effect a government clerk. Meanwhile, doctors from India, Africa and other emerging nations—some of whom studied in Britain, some of whom studied in their own countries—came to Britain and found ready posts in hospitals vacated by the British doctors going elsewhere.

So while a statistician might find the situation little changed by the advent of socialized medicine, the fact is that the British medical situation has changed dramatically.

Today about one half of all emergency surgery in

Britain, to choose one measurable example, is done by non-British-trained doctors. More intangibly but importantly, the professional journals are full of criticism of the quality of British medical practice.

So there is now in Britain a great hullabaloo about what to do to get more able young Englishmen to be English doctors. Yet there are very few so far to ask the simple question: Why should a young English boy want to be an English doctor?

The training for medicine is one of the longest and most arduous of any career. To go through it a young man must be moved by many motives. But those would surely include a desire to make a good living, to enter a profession where he could be his own master and not a hired employee, to have the self-satisfaction of being respected by his community as "the doctor" has ever been. And not the least of the motives is a desire to give to the sick person who comes to him the best care he can provide.

British socialized medicine has taken away every one of those motives, without exception.

The young British doctor, for all his years of study, is paid like a clerk. He is not a "professional man" but a government functionary, and in becoming so he loses the status the doctor once had. He is not his own master even in the practice of his skills. Finally, because the "free" care crowds his anteroom he cannot give the patient before him the time, energy and care he would like to as a good doctor.

Why should anybody be surprised, under such a system, that the able young men are looking elsewhere? Or that thoughtful men should begin to be troubled about the quality of medical care?

Whether all this will in time affect the popularity of the medical program in Britain, we do not know.

But watching it all from afar, we can't help but reflect that here is one place above all where bright and shining promises can cheat the unfortunate while they happily suppose they are counting their blessings.

The North DeKalb Record and Tri County Graphic

1962-63 CALENDAR OF MEETINGS

State

October 25-27—14th Annual Session of the Georgia Academy of General Practice, Atlanta Americana Motor Hotel, Atlanta.

May 5-8—Annual Session, Medical Association of Georgia, Jekyll Island.

Regional

September 14-15—American College of Obstetricians and Gynecologists, District VII, Little Rock, Arkansas.

September 18-20—Kentucky State Medical Association, Brown Hotel, Louisville, Kentucky.

September 24-25—Tennessee Valley Medical Assembly, Chattanooga, Tennessee.

October 4-6—American College of Obstetricians and Gynecologists, District IV, Barringer Hotel, Charlotte, North Carolina.

October 14-17—Medical Society of Virginia, Sheraton-Park Hotel, Washington, D. C.

November 12-15—Southern Medical Association, Hotel Fontainebleau, Miami Beach, Fla.

November 15-17—Southeastern States Cancer Seminar, George Washington Hotel, West Palm Beach, Fla.

National

June 18-20 — American Geriatrics Society, Palmer House, Chicago, Illinois.

June 18-20—American Neurological Association, Claridge Hotel, Atlantic City, New Jersey.

June 19-21—San Diego Symposium on Biomedical Engineering, Stardust Motel, San Diego, California.

June 21-25—American College of Chest Physicians, Morrison Hotel, Chicago, Illinois.

June 21-24 — American Therapeutic Society, McCormick Place, Chicago, Illinois.

June 23-24—American Diabetes Associations, Inc., The Conrad Hilton, Chicago, Illinois.

June 23—American Academy of Tuberculosis Physicians, The Palmer House, Chicago, Illinois.

June 24-28—American Medical Association Annual Session, Chicago.

June 24—Society for Vascular Surgery, Conrad Hilton Hotel, Chicago.

June 27-30—Society of Nuclear Medicine Baker Hotel, Dallas, Tex.

July 9-13—Eleventh Annual Symposium for General Practitioners on Tuberculosis and Other Pulmonary Diseases, Saranac Lake, N. Y.

July 23-27—Postgraduate course in Cardiopulmonary Problems in Children, Edgewater Beach Hotel, Chicago.

August 26-27—American Academy of Physical Medicine and Rehabilitation, Hotel Commodore, New York City.

August 30 - September 8—American Society of Clinical Pathologists, Palmer House, Chicago, Illinois.

September 1-4—College of American Pathologists, Palmer House, Chicago, Illinois.

September 6-8—American Association of Obstetricians and Gynecologists, The Homestead, Hot Springs, Virginia.

September 17-20—American Hospital Association, Chicago.

September 17-November 9—Occupational Medicine, postgraduate course, New York University, New York City.

September 17-21—American College of Chest Physicians postgraduate course, Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, Warwick Hotel, Philadelphia.

October 2-5—American Roentgen Ray Society, Shoreham Hotel, Washington, D. C.

October 4-6—American Medical Association First National Congress on Mental Illness and Health, Palmer House, Chicago.

October 15-19—American College of Surgeons, Clinical Congress, Atlantic City, New Jersey.

October 17-18—American College of Preventive Medicine, Inc., Hotel Fontainebleau, Miami Beach, Fla.

October 20-26—Annual Otolaryngologic Assembly, postgraduate course, University of Illinois College of Medicine, Chicago.

October 22-23—American Cancer Society, Biltmore Hotel, New York City.

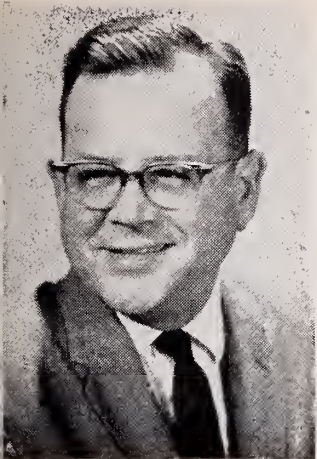
October 22-26—American College of Chest Physicians postgraduate course, Clinical Cardiopulmonary Physiology, Knickerbocker Hotel, Chicago.

October 26-30—American Heart Association, Inc., Sheraton-Cleveland Hotel, Cleveland.

October 27 - November 1 — American Academy of Pediatrics, Palmer House, Chicago, Illinois.

October 28-31—American College of Gastroenterology, The Morrison, Chicago, Illinois.

October 29-31—American Association for the Surgery of Trauma, The Homestead, Hot Springs, Virginia.



PRESIDENT'S LETTER

"A CRAB AIN'T GOT NO SENSE"

THOMAS W. GOODWIN, M.D.

RECENTLY the President of the United States made a political speech at Madison Square Garden. He made it before a Senior Citizens Rally and he spoke in favor of the King-Anderson Bill. Those of you who saw it on television will recall that the President said that we in the United States are 30 years behind Great Britain in our medical care program for the aged. Thank God that we are. It was, in fact, just a little over 30 years ago that Great Britain began her program of State Medicine with exactly the same kind of beginning that the King-Anderson crowd wants to make now. This has grown over the years into a complete regimentation of both doctors and their patients which has become intolerable and which is resulting in a serious drain upon the financial resources of that country.

You also heard the President say that he thought the program as outlined in the King-Anderson Bill was inadequate. He added, however, that this was no reason for not making a beginning, that the program could be improved and expanded later. In view of the experience in Great Britain, these words truly have an ominous ring.

Not long ago I was visiting down on the coast. One afternoon I went into the kitchen where the cook was boiling some crabs. During the course of conversation, the cook, an old Gullah Negro, said to me, "Doctuh, a crab ain't got no sense." "What do you mean?" I asked. "Well," she says "Efn yo tek a live crab and drap him in a bucket of bilen water, he'll scramble and fight t'well he gits outen de bucket. But, efn yo tek dat same crab and put him in a bucket of cold water and sot it on de stove, and turn on de heat kinda gradual like, yo kin bile him alive and he won't never know wat hoppen."

I am sure that you, like I, hope that the people of America have more sense than a crab.

Thomas W. Goodwin
President, Medical Association of Georgia



THE KIND OF ACTION NEEDED IN MENTAL HEALTH PROGRAMS

Don D. Jackson, M.D., *Palo Alto, California*

THE JOINT MISSION on Mental Health, appointed by the Congress of the United States, has recently issued an impressive book, entitled, "Action for Mental Illness." I would like to make some personal observations about the action for mental illness needed and the reasons behind these recommendations.

In the first place, we know that the less rupture that occurs between the mental patient and his status quo, the more quickly and effectively he can assume his usual place in society. This fact has several treatment corollaries. In the first place, we must stop building great steel and stone mausoleums far from town.

Adequate Staffing

We must staff our mental facilities adequately because we know that understaffing does not mean only patient neglect, it results also in a social organization that Goffmann has labeled "the total institution." For the sake of expediency, policies are enacted that are demeaning to the human spirit. Treat a patient like a child, and he will stay a child — at the taxpayer's expense!

We must pay more attention to where the patient comes from and where he will be returning when he leaves the hospital. Further, if psychiatrists were not traditionally tied to their chairs, the proper place to interview most patients who are slated for hospital entry would be in their own homes. I submit that we know little about that group of patients (including how large a group) that need not have entered an inpatient facility in the first place; and that like charity, prevention begins at home.

Not all medical traditions are applicable to psychiatry. For example, the mental patient is worked up intensively on the admission ward but the discharge note may be a sentence or two of poor prose. The next round belongs to the social worker who may be regarded by her psychiatric colleague in the poet's words: "A little better than his horse;

a little dearer than his dog." If this attitude does exist, the social worker senses it and in time so do the patient and his family. Add to this a burdensome caseload and it is not difficult to imagine a too early parting from casework to occur and the start of a new cycle of readmittance to the hospital for the patient.

Where would the manpower and womanpower come from to insure adequate hospital care and good after care for the mentally disordered? It is obvious that sufficient numbers of trained personnel do not exist nor do adequate funds. One possible way out of this dilemma is to focus more attention on promising patients and deliberately face the criticism that such a move would evoke. Preparation for the patient's discharge would begin the moment he entered the hospital with emphasis on relationship between psychiatry, psychology, social work, and nursing.

Ideal Patient Care

Perhaps it would be well to describe a possible facility that would utilize the principles I have been discussing. Located in a city contiguous to the population area from which the patients are to be drawn, the facility would consist of units no larger than approximately 20 patients and would preferably be located in an older home or other non-security type construction. Medical care for the patients would be provided for the patients by their own physicians in the community and if they had no physician, by one appointed from a panel by the local medical society. The patient's family would be required to participate twice weekly in conjoint family therapy sessions with the patient. In addition, group therapy would be offered by the professional staff who would be under the direction of the psychiatric administrator. The patient would be encouraged to leave the hospital from the moment he entered it. His contacts with the community would be maintained through home visits, programs offered by service organizations, part-time volunteers, etc. Combative, assaultive, severely disturbed patients

*Director of Mental Research Institute, Palo Alto Research Foundation.

who could not be quieted with drugs would have to be transferred to a custodial type hospital. Treatment would be concentrated around the problems the patient is having in his work or school and with his family.

The early family visits would be conducted in the home with the therapist present. If it became obvious that the patient and his family could not live together until a great deal of treatment had occurred, the patient would not remain in the hos-

pital but would be transferred as early as possible to some kind of halfway house, boarding home, etc.

Although such a facility sounds expensive, the brevity of the patient's stay may more than make up for the greater daily cost. It is obvious that certain risks would be taken with regard to the possibility of suicide and it is equally obvious that the community would have to be oriented toward helping patients rather than wishing them miles out of town.

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia

UNDER THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

The initial determination of disability is made under agreements between the Federal Government and an agency of the State in which the claimant resides. In most States the vocational rehabilitation agency carries out this responsibility. Thus, a disabled worker has his claim evaluated in the State in which he resides. In addition, every disability claim is reviewed by the State vocational rehabilitation agency to assess the worker's rehabilitation potential so that if vocational rehabilitation services will help him to return to a productive life, he will be offered this help. The medical data in the claimant's file are used for this purpose as well as for determining whether the worker is disabled under the law.

Evaluation of Disability

The evaluation of disability is made by a team in the State agency. There are at least two professional people on each team. One of the two is a physician (often a practicing physician serving the State agency on a part-time basis), and the other is trained in evaluating the personal and vocational aspects of disability. The physician team member is primarily responsible for deciding whether the evidence in the file establishes the existence of a medically determinable impairment with the required severity and duration characteristics. The basis for this determination is the medical reports submitted by the claimant's own medical source, usually his family doctor. Experience has proved that when the complete clinical findings are communicated from the reporting physician to the State agency, disability determinations can be arrived at fairly and quickly.

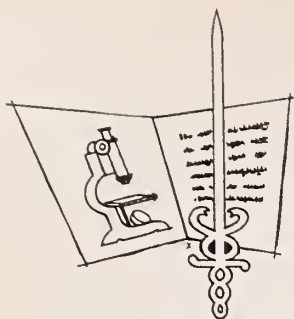
The disability determination is not exclusively a medical finding, however. As a practical matter, it is not

possible to divorce "disability" from the vocational and personal context in which it is found. The vocational specialist looks at the information about the claimant's work history, age, education, and training, and together with the physician equates the claimant's remaining functional capacities with the demands of work. Together they must decide whether the impairment is expected to be of long-continued and indefinite duration and whether it is so severe that it prevents the claimant from engaging in any substantial gainful activity. If this is the case, the claim is allowed and disability benefits are paid.

Clinical or Laboratory Findings

Where the medical evidence initially submitted indicates a reasonable likelihood that the applicant is disabled, but more precise clinical or laboratory findings are needed to arrive at a sound decision or to resolve conflicts in the evidence, the State agency may ask the reporting physician for additional information or may arrange and pay for a consultative examination. The selection of consulting physicians and payment of fees are governed by State practices.

To assure equal treatment of applicants in all parts of the country, the disability determinations made in the State agencies are reviewed by the Division of Disability Operations, Bureau of Old-Age and Survivors Insurance, Baltimore, Md., for consistency and conformity to National policies. The Bureau may reverse a State finding that disability exists, or it may shorten the period of disability found by the State agency. It cannot, however, reverse a finding that no disability exists.



RESURVEY OF CANCER RESEARCH AND ACTIVITIES OF THE AMERICAN CANCER SOCIETY

A. H. Letton, M.D., *Atlanta**

WHENEVER YOU ARE confronted with the question of "what is research doing to find the cause and cure of cancer?" what can you tell them? Let me see if I can at least touch some of the high spots in the space provided. There was a total of \$111,000,000.00 spent this past year on cancer research. This includes the moneys from the National Cancer Institute, as well as the American Cancer Society, and other sources. This includes basic research into the cause of growth, the investigation of immunology and virology, the effect of various chemicals on tumors, as well as the epidemiology of tumors and possible improved techniques in early detection and treatment.

Synthesizing R.N.A. and D.N.A.

Among the basic research achievements within the last four years, outstanding is the fact that two Americans have been recognized as Nobel laureates because of their work in synthesizing R.N.A., and D.N.A., the nucleic acids which are vital to cell reproduction. Other basic research is going on trying to find substitutions on these chemical formulae which will produce a molecule that the cell will still take up which will stop the reproduction of the cell in the future.

Immunology and Virology

The work in immunology and virology apparently is going to be rewarding, and certainly it is most interesting. I would cite you only a few incidences to let you know what is going on. Dr. Sacks, in Richmond, Virginia, has found a filtrable virus which, when given to rats, causes a hemolytic anemia. About 50 per cent of the rats recover from this anemia, and subsequently are immune to it. Serum from these immune rats is then given to rats who are susceptible to Walker 256 carcinosarcoma and Miller's hepatomas, and will cause im-

munity in them to transplantation of these tumors. The dosage of tumor used in the transplantation is enough to produce 98 per cent "takes" in the non-immune rats. In other words, here is a vaccine that, when given to rats, will prevent cancers from being transplanted into them.

Investigators from Roswell Park have been able to induce cancers in animals from the cell-free filtrates of human cancers. This usually produces cancer of the breast in the injected animals, regardless of what type of human cancer used.

What is happening in Chemotherapy? The mechanism of testing many thousand chemicals is quite interesting. Samples of the chemicals are injected into animals growing various types of tumors. The animals are observed and later autopsied. Chemicals showing beneficial results from this injection are studied further by injecting them into other animals in varying amounts under varying conditions. Last year, *of over the 100,000 chemicals* which were tested, *some 400 were found to have beneficial results*; and of this group *only ten* have withstood the tests which have been put to them, and have entered into *clinical trials*. One of the big hold-ups in this project is trying to get the guinea pigs and rats to produce enough new guinea pigs and rats to keep up with the research. It requires 50 animals to test each chemical the first time around, and there have been times when the testing had to wait on the production of animals. This research has unearthed certain chemicals that we might mention. The star of the show apparently is "METHOTREXATE," which, of course, has been used for some time in retarding the onslaught of leukemia. Surgeon General Terry, however, has announced that Methotrexate is a "drug which has almost certainly cured cancer in man." Of course, he is referring to the rather specific action of Methotrexate on choriocarcinoma.

At the present time, the random type research of

*Chairman—Region III, National American Cancer Society, Delegate Member—Georgia Division.

trying almost any drug is slowing down, and is giving way to the synthetic chemists' building new molecules with certain qualities designed to attack cellular growth through their enzyme pathways. "Five-Fluorouracil" is such a drug which has been developed in Wisconsin by Dr. Charles Heidelberger. He has reported that 20 per cent of the carcinomas of the gastrointestinal tract have shown regression. The overall results are not as good as we would like, but we feel that we are on the right track. Another drug is Azauridine developed at Yale. This drug is

unique in that it appears to be non-toxic except to the cancer cell, but as yet it is too difficult to synthesize to enter satisfactorily into the clinical trial stage. The big problems which have come with most of the drugs that have been found to be carcinotoxic, are that they are also so toxic to the other cells of the body that they do as much harm as good.

Next month, I would like to finish by telling you about epidemiological research and what is happening here in Georgia.

Approved by Professional Education Committee, Georgia Division, ASC.

BRIEF SUMMARY OF THE PRESENT STATUS OF SELECTIVE SERVICE AS IT RELATES TO PHYSICIANS

During the calendar year 1961 three Selective Service calls for physicians were issued. This was the first time such calls have been necessary for several years. However, during the past year there was a decrease in volunteers and an increase in the numbers required by the Armed Forces as a result of the mobilization program. This increase in requirement was obtained by:

1. Discontinuing the acceptance of resignation of Regular Officers.
2. Denying release of those Reserve Officers who had voluntarily extended their active duty for an indefinite time.
3. Selective Service call up of 1,025 physicians.
4. Call to active duty of National Guard and Reserve Units with Medical Officers attached.

Because physicians, dentists and other medical specialists, generally speaking, are liable for military service until age 35, and because they may be called as a special group, they were given the following considerations:

1. Those in a Reserve status who were called as filler personnel on or after September 1, 1961 and who had completed at least 21 months' previous active duty were given the opportunity to be released shortly after the activation of the unit.

2. Those Reserve Officers on active duty serving only their required two years were released at the end of their tour.

The physicians called up by Selective Service were those in the youngest age group who had completed their internship. This group, therefore, included almost exclusively first year residents and physicians just beginning private practice. Since the call was based on age it was not evenly distributed and some hospital training programs suffered a depletion of their first year residents while others were untouched.

Because of the possibility of future Selective Service calls for physicians in time of a crisis it would be well to consider the measures which are available to ameliorate the effect on hospital staffs and civilian communities. These are:

1. *Appeal of classification of 1-A (available for military service) to the Appeal Board.*

Shortly after completion of internship, physicians are normally classified by Selective Service in Class 1-A.

An appeal may be made within ten days after receipt of this classification by filing with the local board a written notice of appeal. If the physician is located in an area other than that covered by his local board he may request that his appeal be submitted to the appeal board having jurisdiction over the area where he resides.

2. *Request for determination of essentiality.*

A physician who receives a Selective Service induction notice may, if he is essential to his community or hospital and if his essentiality can be documented, request a determination of such essentiality from his local or State Selective Service Advisory Committee. Copies should be sent to the advisory committee where he is located if this is different from the committee governing the area of the board where the physician is registered. Such a request may also be directed to the National Advisory Committee to the Selective Service System, Washington, D. C.

3. *Delay in reporting to active duty.*

Physicians who have received induction notices and have been commissioned may apply to the Armed Service in which they are commissioned for a delay in reporting to their duty station. Such request must be supported by evidence of essentiality or severe personal hardship.

For those physicians who do not wish to subject themselves to the uncertainties of the draft, the Armed Forces Physicians' Appointment and Residency Consideration Program (Berry Plan) provides for a reserve commission with entry on active duty at one of the following times:

1. Immediately upon completion of internship.
2. As late as one year following internship.
3. Upon completion of residency training in specialties required by the Armed Forces.

Application may be made for participation in this program early during the intern year. Acceptance into any of the three categories is dependent upon the projected needs of the Armed Services.

(Prepared at the request of the AMA Council on National Security by Eugene V. Jobe, M.D., Medical Liaison Representative, AMA Washington Office, and James E. Fitzgerald, M.D., Member, AMA Council on National Security, April 9, 1962).



THE PERIPHERAL VASCULAR DISEASES

J. Edwin Wood, M.D., *Augusta*

THE TERM PERIPHERAL VASCULAR disease has been erroneously used to designate some single but undefined disorder of the blood vessels of the extremities. Actually, a number of wholly different disease processes may involve various segments of the vascular system or the lymphatics of the extremities.

Disorders of the peripheral arterial system fall generally into two groups, obstructive arterial disease most often exemplified by peripheral atherosclerosis or vasospastic arterial disease such as Raynaud's Disease. Atherosclerosis may involve any arterial wall but the most common site of peripheral involvement that comes to the patient's attention is the lower extremity. The degree of atherosclerosis of the legs usually exceeds that of the upper extremities. Walking draws the patient's attention to the disorder through the mechanism of exceeding the ability of the diseased circulation to meet the added blood supply demands of the exercising muscles. Thus, a good history of intermittent claudication is virtually proof-positive of the presence of obstructive arterial disease as differentiated from vasospastic arterial disease or venous disease of the lower extremity. The two most important points in this history are the relatively fixed distance that the patient can walk before lower extremity discomfort stops him and the brief period of minutes that are required for complete recovery that will allow repetition of this walking cycle. Absent or unequal pulses in the lower extremity likewise favor heavily the presence of obstructive vascular disease though vasospasm may cause reduction in pulsation even of large vessels. This possibility may be ruled out by seeing that the patient is physically and mentally comfortable for at least two hours in a warm environment (80° F). Unequal temperatures of the feet suggest obstructive vascular disease strongly but bilateral coolness is so common that it may not be used as a telling sign of this disorder. Thickened toenails, thin, smooth and hairless skin all point to the presence of significant atherosclerosis of the lower extremity.

Raynaud's Disease ordinarily involves the vessels

of the upper extremity. The hallmark of this disorder is its intermittency. Almost by definition Raynaud's Disease is characterized by discoloration of the hand in association with pain. Red, white, or blue discoloration of the skin of the hand not associated with pain is generally called acrocyanosis and undoubtedly deserves separate classification in that it is a completely benign disorder. Marked discoloration of the hand associated with an aching sensation particularly in response to a cold environment, to local cold, or to emotional stimuli speaks strongly for the presence of vasospastic disease of the arterial system that may lead eventually to loss of tissue at the tips of the fingers or even the distal phalanges. This situation is generally observed in nervous young women but not invariably so.

Venous Disease

Disease of the venous system usually involves the lower extremity. While many patients with varicose veins complain of vague symptoms such as aching or tiredness, these symptoms may not be ascribed to venous disorders that cannot be observed by careful physical examination. Chronic venous dysfunction due either to inadequate function of the venous valves or to actual obstruction as a result of repeated bouts of thrombophlebitis, is characterized by brawny edema and pigmentation of the skin of these chronically edematous areas. These findings are not ordinarily present in the sometimes difficult to distinguish arterial disorders that lead to the formation of ulcers on the lower extremity. The absence of the signs described above of arterial disease, aid further in this important differentiation.

Inflammation of the veins, thrombophlebitis, is best distinguished by the acute tenderness of the part involved, usually the calf or foot. If this tenderness can be localized to an area that overlies a vein then the diagnosis of thrombophlebitis is even surer. The presence of heat, redness, and swelling are all evidences of inflammation and likewise favor the

diagnosis of inflammatory disorder of the veins. Acute lymphangitis is a disorder that may be confused with thrombophlebitis and may be distinguished by the disproportionate redness and the exquisite tenderness of the involved extremity as well as specific evidences of bacterial infection.

Chronic lymphedema of an extremity that has resulted from radiation, infection or surgery and lymphedema praecox or congenital lymphedema

(Milroy's Disease) is usually not difficult to distinguish. The patient has no discomfort in the edematous extremity other than that engendered by the sheer weight of the fluid. The skin is *normal* in appearance and the formation of ulcers is rare.

Like most problems of diagnosis in medicine, the most important step lies in the knowledge of the characteristics of a specific disorder and in thinking of it at the time that the patient presents himself.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

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DISASTER TRAINING

All physicians, regardless of their specialty qualifications, should receive training and become proficient in the practice of disaster medicine. All need to become knowledgeable and thoroughly versed in certain principles which are not applicable in normal peacetime medical activities but which will be necessary in the treatment and management of mass casualties during the emergency phase subsequent to an attack. The following are a few examples of the unique principles of health care necessary in a major disaster:

- 1. Treatment procedures and principles must be designed to result in the greatest good to the greatest number.
- 2. Treatment procedures in disaster and support areas must be simplified and standardized.
- 3. Medical laboratory procedures must be held to the absolute minimum.
- 4. The salvage of life takes precedence over the salvage of limbs, and the preservation of function takes precedence over the correction of anatomic defects.

Physicians with specialty qualifications (psychiatrists, radiologists, and others) will need additional preparation in those areas of medical practice from which they may have been separated for some time, particularly in the area of surgery or other direct casualty care. In

addition, all physicians will need some further preparation in certain environmental health aspects of disaster practice, as for example, food and water sanitation and decontamination, and other public health measures.

The Public Health Service has actively supported the Medical Education for National Defense Program (MEND). This program was initiated in 1952 by a MEND Committee to explore methods for introducing into the medical curriculum those special subjects which medical graduates vitally needed if they were to serve competently in the Armed Forces or as civilians in time of national emergencies. Eighty-six medical schools are affiliated with the program which is financed by the three military departments and the Public Health Service. Each year four symposiums are held for the MEND coordinators in order to provide the latest information to each participating school. In addition, a prototype course for inclusion in medical school curriculums is being developed to further assist the schools in providing appropriate instruction material for students. Many schools have also sponsored prototype disaster exercises for student participation. All of these efforts are directed to developing a capability in the potential physician.

NOTE: Abstracted from a statement by Dr. James M. Hundley, Assistant Surgeon General, U. S. Public Health Service as made before the Military Operations Subcommittee of the United States House of Representatives, Second Session, 87th Congress.



Gardner, Edward, Jr., Ph.D.; Claude-Starr Wright, M.D., and Bettie Z. Williams, B.S., Medical College of Georgia, Augusta, Georgia, "The Survival of Virus Treated Erythrocytes in Normal and Splenectomized Rabbits," J. Lab. & Clin. Med. 58:743-750 (Nov.) 61.

The survival of virus-treated erythrocytes in normal and splenectomized rabbits was studied using radio-chromium (Cr^{51}) labeled cells. This investigation is a part of a long-range program attempting to correlate destruction of the damaged or modified red blood cell and the spleen. Erythrocytes were labeled with radio-chromium (Cr^{51}) using *in vitro* and *in vivo* techniques. The survival of normal erythrocytes in normal animals was the same by both technics. Normal erythrocytes in normal rabbits showed a mean apparent half-time survival of 12 days. Intersection of the survival curve with the time axis occurred between 55 and 60 days for those studies carried to completion. Normal erythrocytes in splenectomized animals showed a half-time survival at the upper limits of normal. Erythrocytes treated with influenza and Newcastle disease virus showed a shortened survival time in normal rabbits. Newcastle disease virus apparently produced more damage to the red blood cells than influenza virus as judged by the markedly shortened survival of cells treated with this agent. Erythrocytes treated with influenza virus appeared to survive longer in rabbits [previous splenectomized]. These findings suggest that the removal of this source of reticuloendothelial tissue prevented a more rapid removal of the virus-modified cells from the general circulation.

Bloom, Walter L., M.D., 1968 Peachtree Road, N.W., Atlanta 9, Georgia, "The Comparison of the Apparent Volume of Distribution of Large Molecular Weight Dextran and Evans Blue Dye," J. Lab. & Clin. Med. 58:605-612 (Oct.) 61.

A simultaneous measurement in hospitalized patients of the apparent volume of distribution (AVD) of Evans Blue dye was compared with the AVD of three different molecular size ranges (195,000, 255,000 and 412,000) of dextran. Statistical analysis of relationship of the slope of dye or dextran concentration with time indicated that extrapolation to zero time increased the variability of the data. Simultaneous measurement of the AVD of dye and dextran in the same patient indicated small differences in the two methods. Large molecular weight dextran fractions thus may be used to measure plasma volume. The dextran measured in whole blood was shown

to provide a means of estimation of whole blood volume. A chemical estimate of hematocrit was also demonstrated. The use of macromolecules of defined molecular range have been shown to present new possibilities of estimation of vascular volumes as well as providing an eventual method for chemical measurement of capillary permeabilities.

Rieser, Charles, M.D., 819 Cypress Street, N.E., Atlanta 8, Georgia, "The Etiology of Retrograde Ejaculation and a Method for Insemination," Fertility & Sterility 12:488-492 (Sept.-Oct.) 61.

A description of the presently accepted concept of the neuro-physiology of antegrade ejaculation is presented. Integrity of the vesical neck is required to prevent retrograde expulsion of the semen into the cavity of the bladder. Retrograde ejaculation results from surgery in the area of the vesical neck or its nerve supply (disease or surgery of the thoraco lumbar sympathetics or its tributaries). The post prostatectomy sexual experiences of 105 patient were analyzed. Transurethral prostatectomy resulted in retrograde ejaculation in 42 per cent of patients whereas all patients who underwent suprapubic and retro-pubic prostatectomy experienced normal antegrade semen propulsion. A case report is presented revealing a method of producing conception in an instance where the male partner suffered from retrograde ejaculation. The semen was retrieved from the bladder by catheter immediately following ejaculation and directly inseminated into the vagina of the female partner. Successful conception occurred.

Vogel, R. A., Ph.D.; T. F. Sellers Jr. M.D.; and Patrick Woodward V.A. Hospital Atlanta Georgia "Fluorescent Antibody Techniques Applied to the Study of Human Cryptococcosis" J.A.M.A. 178:921-923 (Dec. 2) 61.

In a previous report (Vogel, R. A., and Padula, J., Proc. Soc. Exp. Biol. and Med. 98:135-139, 1958), an indirect fluorescent antibody test was described which detected antibodies in cases of Histoplasmosis, Blastomycosis, and Cryptococcosis. The work reported in this paper deals with the application of this technique in several cases of Cryptococcosis, unrelated disease, and normal human sera.

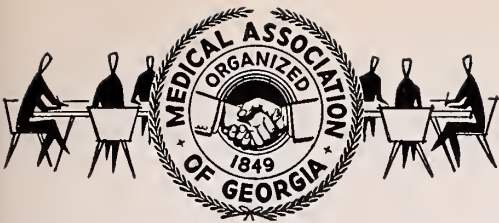
All but one of seven cases of culturally proven, acute Cryptococcal disease gave a characteristic positive reaction. A case which involved only the adrenal gland failed to give a positive reaction. Equally strong reactions were obtained with heterologous and homologous strains of *Cryptococcus neoformans*.

Findley Thomas, M.D., Medical College of Georgia, Augusta, Georgia, "The Nephrotic Syndrome," Am. Heart J. 61:822-840 (June) 61.

CURRENT VIEWS REGARDING the etiology, pathogenesis, differential diagnosis and treatment of the various diseases which occasionally manifest themselves by the nephritic syndrome are discussed. Perhaps the only new feature worth calling attention to is the finding by Harms that even the normal kidney possesses an unusual ability to breakdown serum albumin into smaller fragments, and that this proteolytic activity is increased in animals with anti-kidney serum nephritis. The kidney may be a more important organ in intermediary protein metabolism than is commonly thought.

Greenberg, Wayne V., M.D. Medical College of Georgia, Augusta, Georgia, "Addison's Disease and Hyperthyroidism," Ann. Int. Med. 55:663-667 (Oct.) 61

The simultaneous or sequential occurrence of multiple endocrinopathies in the same patient confuses both clinical evaluation and therapy because the presence of one disorder may alter the manifestations of the second. The case reported in this article is that of a patient with documented and treated Addison's disease who, at a later date, developed symptoms of nervousness, weight loss and tachycardia of 110 per minute. There were no abnormal eye findings and the thyroid gland was enlarged. Laboratory evaluation revealed an elevated protein bound iodine, an elevated radio iodine uptake and a high PBI-131. Paradoxically, the basal metabolic rate was low and the serum cholesterol was somewhat elevated. These unusual values for hyperthyroidism can be explained by recent observations concerning the physiologic effect of androsterone. This steroid is "thyromimetic" in that it elevates oxygen consumption and lowers blood cholesterol. Furthermore, there is suggestive evidence that androsterone is in part responsible for the increase in oxygen consumption and lowering of the cholesterol in hyperthyroidism. It is postulated that in the absence of functioning adrenal glands, hyperthyroidism would not result in an elevation of oxygen consumption or a lowering of serum cholesterol since androsterone is absent. Substitution therapy with cortisone would not correct this defect and may, in fact, aggravate it by suppressing any androsterone production by the residual adrenal tissue. The patient herein reported responded in the usual fashion to therapy with propylthiouracil.



THE ASSOCIATION

DEATHS

WARREN WALTER GREMMEL of Atlanta died at the age of 41 in a light plane crash on April 1, 1962. He had left his practice of medicine on September 1, 1961 and returned to the United States Air Force as a major.

Dr. Gremmel attended the University of Texas Medical School and served his internship at Robert B. Green Hospital in Austin, Texas and residency at the U.S.A.F. School of Aviation Medicine at Randolph Air Force Base.

He was the former vice president of the Atlanta International Raceway. Dr. Gremmel was recently doing special work at the Rochester School of Medicine and Dentistry in Rochester, N. Y. He was a member of the Medical Association of Georgia, the American Medical Association, the Fulton County Medical Society, the Academy of General Practice and the Association of Military Surgeons.

He is survived by his widow, three small sons, his mother and a brother.

HILTON F. WALL, Atlanta, 44, died April 6, 1962. Dr. Wall was born and reared in Atlanta.

He was graduated Phi Beta Kappa from the University of Georgia and Emory University Medical School. During World War II he served as a captain in the Army Medical Corps.

Dr. Wall served as diplomate of the American Board of Surgeons and was a fellow of the American College of Surgeons. He was a member of the American Medical Association, the Medical Association of Georgia, the Fulton County Medical Society, the Northwest Presbyterian Church, Brookhaven Rotary Club, Capital City Club, Cherokee Town and Country Club and Allatoona Yacht Club.

Survivors include his widow, Dorothy Harris Wall; a son, Hilton F. Wall, Jr.; his mother, Mrs. James P. Wall and a brother, James P. Wall, Jr., Greensboro, N.C.

HENRY H. OLLIFF, SR., 77, of Bulloch County died April 12, 1962 in Register. He had practiced medicine there for 53 years.

Dr. Olliff was graduated from Emory University Medical School in 1919. He was a member of the American Medical Association, the Medical Association of Georgia and the Bulloch-Candler-Evans Medical Society.

His survivors include his widow Eva Irene Cates Olliff; two sons, H. H. Olliff, Jr. of Register and Ben C. Olliff of Griffin; a daughter, Mrs. Ralph Gaskins of Griffin; a sister, Mrs. M. E. Ashe of Miami, Fla.; three brothers, B. R. Olliff of Statesboro; John F. Olliff of Register and Walter E. Olliff of Bristol; seven grandchildren; a great-grandchild and several nieces and nephews.

THOMAS IRVIN WILLINGHAM, Atlanta, died at the age of 61 in an automobile accident. Dr. Willingham had practiced medicine in Atlanta for 37 years.

He was a graduate of Emory University and Emory University Medical School, and specialized in pediatrics at St. Louis Children's Hospital in St. Louis.

Dr. Willingham was a member of the Medical Association of Georgia, the American Medical Association, the Fulton County Medical Society, the American Academy of Pediatrics, the Southern Medical Association and was former chairman of the Atlanta Tuberculosis Association. He was a member and steward at Peachtree Road Methodist Church, Brookwood Rotary Club and the Atlanta Yacht Club.

He is survived by his widow, Scott Meador Willingham; a son, Thomas Irvin Willingham, Jr.; daughters, Mrs. George Kirkpatrick of Nashville, Tenn. and Miss Anna Willingham of Atlanta; brothers, J. Bryan Willingham, Fred N. Willingham and J. N. Willingham, all of Atlanta; W. Bernard Willingham of Louisville, Ky.; J. Parks Willingham of Macon; and Paul Willingham of Dallas, Tex.; sisters, Mrs. Caughey Culpepper of Atlanta, Mrs. A. S. Noble of Greenwich, Conn. and Mrs. Cam Young of Valdosta.

DICK RANDOLPH LONGINO, 73, retired Atlanta physician, died April 26, 1962 at his home in Lakeland, Fla.

Dr. Longino was a graduate of Emory University School of Medicine and attended New York Postgraduate School and Hospital in New York City. He had practiced medicine in Atlanta for more than 50 years.

He was a member of the Medical Association of Georgia, the Fulton County Medical Society, the Southern Medical Association and the American Medical Association.

Dr. Longino is survived by his widow, Evelyn Estes Longino; three sons, Col. D. R. Longino, Jr., of Natick, Mass.; Comdr. Walter B. Longino of Brunswick and Dr. Grady E. Longino of Lakeland, Fla.

ARTHUR LEE HORTON, 77, of Cartersville died May 4, 1962. He was a life member of the Medical Association of Georgia.

Dr. Horton was a graduate of the Georgia College of Eclectic Medicine and Surgery. He had formerly practiced medicine in Ranger, Adairsville, Taylorsville and Cartersville.

He was a member of the American Medical Association and a life member of the Bartow County Medical Society.

Survivors include his widow, Bertha Bobo Horton; a daughter, Miss Anne Horton of DeKalb, Ill.; a son, A. L. Horton, Jr., of Tampa, Fla.; a brother, J. G. Horton of Lithonia; sisters, Mrs. Hugh Green of Calhoun; Mrs. A. L. Sayer, Miss Ina Horton of Atlanta and three grandchildren.

SOCIETIES

CARROLL - DOUGLAS - HARALSON MEDICAL SOCIETY met April 2 in Tallapoosa. The scientific program, a case history and brief discussion of thrombosis of the posterior inferior cerebellar artery, was presented by J. H. Beall.

GEORGIA MEDICAL SOCIETY met at their headquarters in Savannah on April 10 to hear William Waring speak on "Concepts of Pulmonary Function in Children."

GLYNN COUNTY MEDICAL SOCIETY met in Brunswick on April 17 and Marvin Engel presented a portion of the paper he is working on concerned with the investigation of the chemo-toxic hepatocellular reaction to triacetylolandeomycin.

MUSCOGEE COUNTY MEDICAL SOCIETY sponsored a program May 4 on WRBL-TV that was designed to answer the question of medical care for the aged, entitled "Whither Medicine."

POLK COUNTY MEDICAL SOCIETY met in Cedartown at Polk General Hospital on April 17. The scientific program, "Office Urology," was presented by Ted Staton of Atlanta.

WARE COUNTY MEDICAL SOCIETY met May 3 in Waycross and heard a scientific program by T. J. Ferrell.

PERSONALS

First District

H. W. SMITH of Swainsboro attended on March 20-22, a short postgraduate course on Pre- and Postoperative Care, held at the Medical College of Georgia in Augusta.

H. I. CONNER of Vidalia during April, attended the annual American Academy of General Practice meeting in Las Vegas.

G. B. HOGSETTE of Sylvania attended a postgraduate course on Trauma presented by the American College of Surgeons Committee on Trauma in Chicago on April 25-28.

Second District

J. J. COLLINS of Thomasville was elected president of the Second District Medical Society at their meeting in Albany on April 5.

Third District

J. C. SERRATO, JR. of Columbus lectured at the meeting of the Latin American Orthopedic Society which was held in Bogota, Columbia in South America during the month of January.

Fourth District

EVAN MOLYNEAUX of LaGrange spoke to the

Pleasant Grove Community Club on March 17. His subject was Cancer.

Fifth District

JAMES T. KING of Atlanta announced April 1 the limitation of his practice to laryngopharyngology and otology.

TED F. LEIGH of Atlanta was guest speaker at the annual meetings of the Mississippi State Medical Association in Jackson, Miss. and the Florida State Medical Association in Miami Beach during the early part of May.

BRUCE LOGUE of Atlanta was guest lecturer at the Eighth Annual Seminar presented by the Huron Road Hospital, Cleveland, Ohio, on May 4-5. The title of his talk was "Subtle Pulmonary Signs and Symptoms of Left Heart Failure."

DAVID HENRY POER of Atlanta was elected first vice president of the Association of Surgeons of the Southern Railway System at their meeting April 17-19 in Atlanta.

JOHN T. MAULDIN of Atlanta was guest speaker, April 12 at the Winder Kiwanis Club. He spoke on Cancer of the Colon.

WILLIAM A. HOPKINS of Atlanta was elected president of the Atlanta Tuberculosis Association at their annual meeting held at the Academy of Medicine on April 26.

Sixth District

W. S. HELTON and WILLIAM RAWLINGS of Sandersville attended the postgraduate course on Pre- and Postoperative Care held March 20-22 at the Medical College of Georgia in Augusta.

BEVERLY W. FORESTER of Macon was appointed by Gov. Vandiver on April 3 to the State Board of Health.

Z. S. SIKES of Macon spoke on "Parent Problems and Problem Children" before the Macon Parents League on April 24 at the local YMCA.

R. M. REIFLER of Macon on May 6 was elected as secretary-treasurer of the Georgia Society of Dermatologists at their meeting in Savannah.

Seventh District

R. D. ALLEN of Tallapoosa was recently elected mayor of that town.

H. L. BARKER of Carrollton was named by the Carrollton Chamber of Commerce as the "Man of the Year for 1961."

CALVIN EDWARDS of Dalton was recently re-elected medical department secretary at the 15th biennial business session of the Georgia-Cumberland Conference of Seventh-Day Adventists at Collegedale, Tenn.

JAMES H. MANNING of Marietta recently resigned the post of Cobb County's medical examiner and W. A. SHERRER of Marietta moved up from assistant Cobb medical examiner to the position.

HAROLD McLENDON of Carrollton recently passed his board examination in specialty fields of obstetrics and gynecology.

Eighth District

MARVIN F. ENGEL of Brunswick was elected Chairman of the Georgia Society of Dermatologists on May 6 at their meeting.

Ninth District

H. H. McNEELY of Toccoa attended during the week of April 6 the 1962 Clinical Congress of Abdominal Surgeons in Chicago where he was inducted into the American Society of Abdominal Surgeons.

JAMES D. SCHULER formerly of Ellijay has moved to Wytheville, Va. where he is the Surgeon for the Wytheville Sanitarium and Hospital.

Tenth District

WILLIAM S. BOYD of Augusta gave an exhibit of his paintings at the Augusta-Richmond County Library on April 10.

JACK B. WILLIAMS of Augusta on April 7 showed a rescue breathing film and demonstrated mouth to mouth resuscitation at the meeting of the Augusta Junior Woman's Club.

EXECUTIVE COMMITTEE OF COUNCIL

THE APRIL MEETING OF the Executive Committee of Council was called to order by the Chairman Fred H. Simonton, at 1:55 P.M., at MAG Headquarters.

Those attending were Fred H. Simonton, Chickamauga, John T. Mauldin, Atlanta, and J. G. McDaniel, Atlanta. Also attending this meeting were Edgar Woody, Jr., Editor, JMAG, and Mr. M. D. Krueger, Mr. J. M. Moffett and Mrs. Catherine Wooten, of the MAG staff.

On motion duly made and seconded it was voted to dispense with the reading of the minutes of the March meeting of Council and Executive Committee, as the minutes had been mailed to the members previously, and to approve the minutes as published.

Certificates of Appreciation

Secretary Mauldin asked the Executive Committee's opinion regarding the awarding of Certificates of Appreciation to Vice Councilors whose terms of office expire and who do not aspire to re-election. It was recommended that Certificates of Appreciation be awarded to the Vice Councilors this year and that

the matter be brought before Council for reappraisal at the June meeting.

Spalding County Medical Society Resolution Regarding Civil Defense Problems

Secretary Mauldin asked for proper disposition of the Resolution submitted by the Spalding County Medical Society regarding Civil Defense Problems. It was recommended that the AMA be contacted for determination if AMA opposes introduction of such a resolution as a Council Resolution; and that a report of AMA's opinion be given to Council at the May 5th meeting.

Increase in Printing of JMAG

Editor Edgar Woody informed Executive Committee of the increase in printing costs of the JMAG. An adjustment in the printing cost was discussed (five per cent increase as of July 1, 1962 and five per cent as of January 1, 1963) and after discussion it was decided that this was in line with other bids. It was the Executive Committee's opinion that the printer now being used should be retained as printer for the JMAG.

New Business

On motion duly made and seconded the following actions were taken:

(1) Letter about Dr. Merrill Lineback referred to Fulton County Medical Society for reply.

(2) Eugenic Sterilization letter referred to the Board of Legislation and the MAG Attorney for recommendations and report to the Executive Committee at the June meeting.

(3) Richardson Resolution referred to the President of the Bibb County Medical Society for presentation by their Delegate to the House of Delegates.

(4) Atlanta Constitution article on cost of medical care program in Georgia was discussed. It was recommended that a reply from MAG over the President's signature be sent to the paper refuting their inaccurate statements.

(5) Freedman letter regarding the problem concerning organized medicine's solution of the development of community health services referred to the Board of Governmental Medical Services for consideration.

(6) Los Angeles County Medical Society plan for influencing the course of the King-Anderson Bill was referred to the Board of Legislation.

(7) State Board of Health Meeting Report was given by Dr. Simonton and the 1962 Codification of Public Health Laws was submitted for consideration. He stated that while the "Family Responsibility" Section of the proposed bill does not appear in the copy submitted to MAG, the Board of Health had voted to restore this section to the bill.

There being no further business the meeting was adjourned at 3:10 P.M.

NEW PROGRAM TO SEEK BETTER METHODS OF MEDICAL EDUCATION

A program to help intensify the teaching effectiveness of medical educators thereby increasing the ability of medical students to learn has come into being by a grant to the Association of American Medical Colleges.

According to Dr. Ward Darley, Executive Director of AAMC, the \$300,000 five-year grant was made by the Carnegie Corporation of New York as part of its continuing interest in higher education.

Dr. Darley said that the AAMC has organized an "educational division" within the association to implement the program which will emphasize research in medical teaching and learning.

Dr. Paul J. Sanazaro, Associate Professor of Medicine, University of California Medical Center, San Francisco, has been named to head the AAMC's new educational division. Dr. Sanazaro received his M.D. degree from the University of California in 1946.

The division will have as one of its goals that of delving into patterns of teaching and learning as applied to medical education. The information and data thus gained will be distributed to all medical colleges through forums and seminars and the association's publication, Journal of Medical Education, he pointed out.

Dr. Darley said that the AAMC Education Division will work with medical schools to initiate specific study and research with a view to stimulating development of a more critical analysis of fundamental teaching and learning by way of psychological measurements.

"The intent of the division is not to standardize or to foster uniformity but rather to provide efficient access to the best medical teaching methods available. One very important long-term benefit AAMC expects will be the incorporating of the best thinking of educators and behavioral scientists into an available pool of knowledge.



Glimpses at Annual Session



Medical association of Georgia. Journal

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CAUTION NOTICE

Frequent and excessive use
is habit-forming, tends to
overexcite paternalistic
glands, often deadens
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The incidence of postoperative wound infections, particularly among debilitated patients, presents a serious hospital problem.¹ These infections are caused in many cases by strains of staphylococci resistant to most antibiotics in common use.^{1,2,3} In such instances, CHLOROMYCETIN should be considered, since "...the very great majority of the so-called resistant staphylococci are susceptible to its action."⁴

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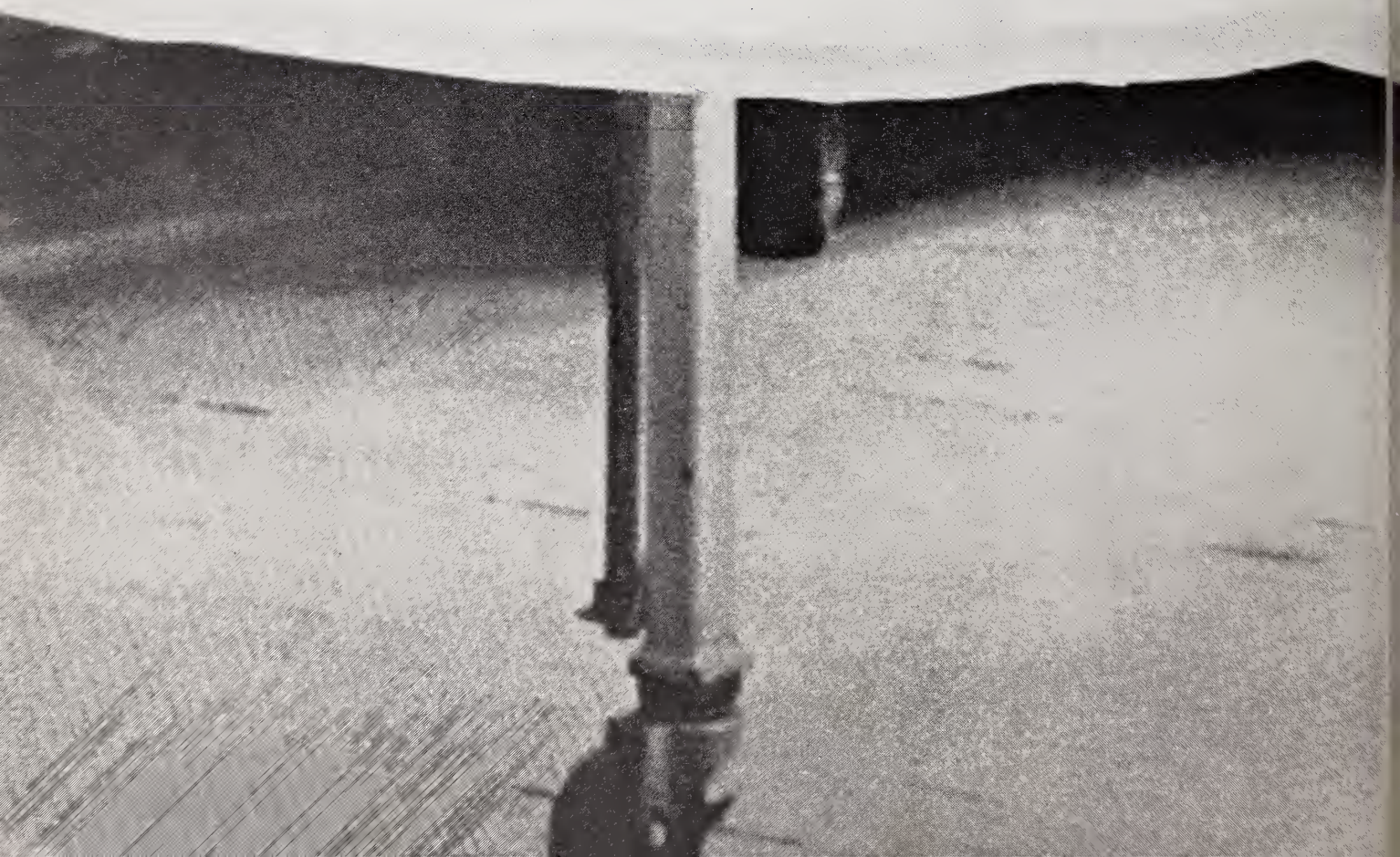
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CALCIFIED FECALITHS IN THE APPENDIX — THE RELATIONSHIP TO ACUTE DISEASE

J. D. Martin, Jr., M.D., and Frank C. Jones, Jr., M.D., *Atlanta*

- *The frequency of this change does not occur often enough to be of real diagnostic aid in making use of routine radiographs in patients with suspected acute appendicitis*

THE PRESENCE OF CALCIFIED foreign bodies in the appendix may be of endogenous or exogenous origin. Unlike those in intestine, they are more frequently of the endogenous variety. Such conditions may be without symptoms or physical evidence.

The wide variation of opinion in the literature concerning the incidence of calcified fecaliths of the appendix seems to result from the interpretation of a visualized radiopaque mass. Some investigators distinguish between a concretion with the appearance and hardness of stone, and the laminated appearance of a calcified fecalith with layers of calcium salts at its periphery. Kjellman¹ reviewed 557 cases of acute appendicitis in the literature and found incidence of 34 with radiopaque appendiceal lithiasis.

In Steinert's series,² 31 fecaliths were present at operation, although only ten were demonstrated by roentgenogram. All cases with radiopaque fecaliths were either gangrenous or perforated. Berg and Berg³ state that approximately 25 per cent of appendiceal fecaliths have sufficient calcium to be seen radiographically.

Acute appendicitis can be easily recognized, or it can be one of the most difficult diagnostic problems encountered. In 1911, there were more than 18,000 deaths from appendicitis. Since 1939,⁴ the mortality rate was decreased by only 1,000. With the introduc-

tion of penicillin in 1944, and other antibiotics in succeeding years, the rate has been reduced 78 per cent. However, as late as 1957, there were still 2,090 deaths from appendicitis. For these reasons, every means of arriving at an early diagnosis and the institution of proper therapy is imperative.

In the acute abdomen, and especially appendicitis, diagnoses can most often be made from the history and the physical examination. However, in certain atypical cases, when diagnosis is a problem, a flat roentgen film of the abdomen can be helpful. When a calcified fecalith can be demonstrated in a patient with acute abdominal symptoms, according to Berg,³ there is a 90 per cent chance that the patient has acute appendicitis, and in 50 per cent of the cases, that the appendix is gangrenous or perforated.

Various terms, such as coproliths, stercoroliths, enteroliths, fecaliths, concretions, stones and calculi, have been used to describe radiopaque material in the appendix. Since these concretions are the result of calcification of retained fecal material in the appendix, the most appropriate term would seem to be calcified appendiceal fecalith. In 1906, Weisflog⁵ was the first to report such in which a diagnosis was made preoperatively by radiograph, and since then, 179 cases have appeared in the literature.

The most commonly accepted theory of the mechanism of development of these conditions is outlined by Kelly and Hurdon.⁶ There is stasis of fecal material in the appendix which causes in-

From the Joseph B. Whitehead Department of Surgery, Emory University School of Medicine, Atlanta, Georgia.

spissation and irritation of the mucosa, resulting in a low-grade inflammatory process. Excessive mucous is secreted along with organic salts, particularly calcium phosphate, which are precipitated around the periphery of the fecalith. These enlarge, and concentric layers of calcium salts give the concretion its laminated appearance. As it increases in size, obstruction of the appendix occurs, which may produce the typical signs and symptoms of acute inflammation.

Atwell and Pollock⁷ found the true calcified intestinal enteroliths to contain calcium salts or choleic acid. The combination of the two conditions may most likely occur. Although seldom mentioned, the presence of choleic acid origin must be considered as a beginning of the lesions which are later encountered.

Felson and Bernhard⁸ reviewed all reported cases of calcified appendiceal fecaliths to 1947, describing their physical characteristics: in 68 per cent of the cases, concretion was single; in size, 77 per cent were 2 cm or less in diameter; in 90 per cent, the shape was oval or round, the remainder being triangular or irregular. Ninety-four per cent had calcific lamination, and 73 per cent were of hard consistency.

According to Felson and Bernhard,⁸ over 90 per cent of the cases present the picture of acute appendicitis, and of these, approximately 50 per cent are ruptured. Other studies support this conclusion, consequently, diagnosis may be assisted by roentgenographic findings. The radiological features of the calcified appendiceal fecalith are fairly characteristic. Candy⁹ reports that the opacity is usually within a 15 cm radius of the mid-point of the right ileum, or wherever the appendix is situated. Fecaliths generally are oval and occur singly, but multiple opacities are found and they tend to lie either in a curve or a straight line. Commonly, the size on a roentgenogram is from one-three cm, and lamination is an almost constant feature. The differential diagnosis of an opacity of this type is not often a problem, but a calculus in the right ureter should be considered. Gallstones, phleboliths, barium residue, foreign bodies, calcified lymph nodes, bone islands in the ileum, calcified arteries seen on end, calcified cysts, film artifacts, and papillomas of the skin are possibilities which must be excluded.

Case Reports

Case 1 (J.W.): A 17-year-old male, as well as the other cases to be reported, was seen by Dr. Lloyd Timberlake and admitted to Emory University Hospital with an acute abdominal pain. Examina-



Figure 1
Roentgenogram of patient demonstrating large, laminated fecalith in the appendix with associated ileus.

tion showed a well-nourished young man with normal vital signs except for a temperature of 99°. He complained of continuous dull pain in the right lower quadrant of the abdomen of a few hours' duration. There had been no nausea or vomiting. Two months prior, a similar incident had occurred and subsided in one week. Abdominal examination revealed no acute tenderness or definite masses. The laboratory report showed his hemoglobin to be 15.6 gm, with a leucocyte count of 10,300. A flat plate of the abdomen showed a small opaque object in the right lower quadrant in the region of the appendix.

At operation the appendix was noted to be very firm, injected in its distal portion and swollen to a diameter of 1.5 cm in the proximal area. A fecalith was felt in the mid-portion. Numerous adhesions surrounded the appendix, from the site of the obstruction of the lumen to the tip.

The pathologist's report showed the appendix to be 6.5 cm long and one cm in circumference, except for the upper portion, where there was marked dilatation, with a circumference of 2.5 cm. A stone-like mass measuring 1.8 x 1.4 x 1.0 cm. was present. Under microscopic examination the layers of the appendiceal wall appeared intact.

Postoperatively, the patient had an uneventful hospital course.

Case 2 (C. W.): An 18-year-old, well-nourished female, the sister of the first patient, was admitted to Emory University Hospital with acute pain of 24 hours' duration, which had localized to the right lower quadrant. On the previous day she had had a normal bowel movement.

Abdominal examination revealed right lower quadrant tenderness, with moderate guarding, but no masses were noted. Rectal examination showed tenderness on the right. Laboratory examinations showed hemoglobin of 13 gm and white blood count to be 13,400.

At operation the appendix was found acutely inflamed, with a large fusiform mass in its proximal portion.

The pathological examination revealed that the appendix measured 6.5 x 2.1 cm. The serosal surface and its mucosa were minimally injected. The fecalith measured 3.5 x 0.4 cm and appeared to contain calcium salts. Under microscopic examination there was ulceration of the mucosa with edema, leucocytic infiltration of the wall, and a fibrinous exudate.

The patient's postoperative course was uneventful.

Case 3 (M. W.): A well-nourished, 20-year-old female, the sister of Cases 1 and 2, was admitted to Emory University Hospital on July 22, 1957, with acute lower abdominal pain of 24 hours' duration. On admission, the pain had gradually intensified and localized to the right lower quadrant. For twelve hours she had been nauseated, but had not vomited.

Abdominal examination revealed marked right lower quadrant tenderness, with rebound, and moderate muscle spasm. Rectal examination revealed tenderness on the right, but no masses were felt. Blood pressure and pulse were normal, temperature 100°. Laboratory examination showed white blood count to be 13,100.

At operation the appendix appeared enlarged, congested, and inflamed, and a mass was palpable in the mid-portion. The pathological examination revealed the appendix to be 8.0 x 1.5 cm and to show evidence of acute inflammation. The palpable mass near the tip, on cross-section examination, revealed a calcified fecalith. The region distal to the mass was completely occluded. Under microscopic examination, numerous ulcerations of the mucosa, with inflammatory cells in the wall, were noted. The submucosa showed extensive areas of old scarring. A thin fibrinous exudate covered the serosal surface.

The presence of fecal material within the lumen of the appendix is a common finding. As has been previously noted, when these remain present for a long time, there is opportunity for calcification. The fact that this occurred in three young teen-age members of the same family is significant. The exact mechanism involved in the development of such pathological processes in the same family is not clear.

The role of diet may be offered for conjecture in the production of these conditions. This is particularly true since these processes occurred in patients who were on the same diet and may most likely have had similar or related habits. This may well be significant since the incidence of appendicitis among more primitive people is thought to be less than among those accustomed to the modern diet.

The frequency of this change does not occur often enough to be of real diagnostic aid in making use of routine radiographs in patients with suspected acute appendicitis. In the isolated instance and in the obscure case, benefits may be found from scout films of the abdomen.

As previously noted, the clinical evidence of the acute abdomen and especially that of acute appendicitis may be obvious, and again, all signs may be completely absent. The dependence on the signs and symptoms and usual laboratory evidence must remain as the means of arriving at an early diagnosis.



Figure 2

Roentgenogram demonstrating concentric, calcified fecalith in the appendix associated with acute inflammation.

The factors implicated in the production of calcified fecalith must first be related to the basic anatomical arrangement of the organ. The lumen must be patent but with sufficient stasis, whether related to interference from lack of mobility from one cause or another, or from that of simple inspissation with its consequences. The associated infection is of significance in the production of these changes. Disarrangement of calcium metabolism, as seen in inflammatory processes, has long been known, and to be manifested by the deposition in these instances.

Summary

1. Three cases of calcified appendiceal fecaliths are reported which occurred in two sisters and a brother.

2. The manifestations were shown to be associated with acute appendicitis.

3. Roentgenograms demonstrated the presence of calcification, although it was not essential in making the diagnosis of this condition in any of these patients.

4. The occurrence and frequency of calcification in the appendix is discussed; the possible mechanism is presented.

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THE EMPTY PROMISE

Generally overlooked in the heated argument over the proposed King-Anderson bill to provide restricted health aid to the aged through Social Security, is the ominous fact that this would be the first time the beneficiaries, under Social Security, would not be paid off in money.

They have been promised services in lieu of setting up the central government either directly or indirectly in the hospital business. This is the wedge which responsible citizens, doctors or not, have reason to note and to fear.

Proponents of this highly emotional issue have soft-pedaled the fact that under the bill any provider of services—meaning hospital or nursing home—would have to apply for permission to accept this kind of business. The government would license those institutions which, presumably, wanted this business under terms of payment set up by the Department of Health, Education and Welfare. HEW would administer and pay the bills.

But suppose, as is likely, the government could not furnish nearly enough hospital or nursing home space under the conditions it sets up? Suppose private institutions do not volunteer because of any of several reasons—payments, specifications or capacity already attained? What does the government do then?

Obviously to make good its promises it would have

to go into the business of building and staffing its own hospitals and nursing homes. It would have to take billions of the general taxpayers' money and divert it to this end. The alternative would be government control of existing private hospitals and nursing homes to force them to accept patients and payments as the government would direct.

In other words, the repeated assertion by hired government propagandists (at taxpayers' expense), that under the health bill some 15,000,000 Americans would have free choice of facilities, is a lot of nonsense. It is just as nonsensical as the repeated complaint that doctors (even though they are citizens and taxpayers) should have no voice in the matter because they (doctors) wouldn't get their fees under the legislation. The King-Anderson measure is another move to diminish the "private sector" of our economy and our way of life and enlarge the "public sector" under the reasoning that nobody can take care of himself and the government must control everything.

The pity is that some people, notably trade union chieftains, have gone along with this proposal, obviously to pay off political support, without realizing that if the bill passes they will be giving up some of the freedom which unions cherish so highly and for which they are willing to make great sacrifices.

Cleveland Ohio Plain Dealer

DIABETIC GLOMERULOSCLEROSIS

Joseph P. Bailey Jr., M.D., Augusta

■ *In the author's experience there is no statistical difference in the incidence of hypertension in the patients with or without glomerulosclerosis*

SOME 25 YEARS AGO Kimmelstiel and Wilson⁹ described a peculiar lesion in the glomeruli of kidneys from patients with diabetes mellitus and the nephrotic syndrome. Since that time many papers on this entity have been published, most of which designate the pathologic lesion as *intercapillary glomerulosclerosis* and the clinical picture as the *Kimmelstiel-Wilson syndrome*. There has been much discussion about the association of clinical findings with this lesion, and recent work^{5,6} indicates still another lesion, said to be even more closely related to the severity of the clinical findings. The purpose of this paper is to review some of the recent work on diabetic glomerulosclerosis with particular reference to the clinical and pathologic findings in 21 cases of proven diabetes mellitus at this institution.

Lesions in Three Groups

The pathologic lesions of diabetic glomerulosclerosis can be separated into three groups¹¹:—nodular, diffuse, and exudative. The nodular lesion is the one first described by Kimmelstiel and Wilson, who at the time thought it to arise from the intercapillary connective tissue of the glomerulus.⁹ It usually lies in the peripheral portion of the glomerulus, takes on a reddish hue when stained with hematoxylin and eosin and the periodic acid-Schiff stain brings out a laminated appearance. Nuclei are generally found near the periphery of the nodule with only occasional ones in the central portion.

The diffuse lesion as described by Bell^{1,2} has recently been attributed to changes arising in the basement membrane of the glomerulus.^{3,5,6} It appears initially in the periphery of a few glomeruli but usu-

ally proceeds to involve all of the glomerulus by concentric thickening of the basement membrane with an eosinophilic material. The endothelial cells of the glomerular capillaries become completely surrounded by this substance.

The exudative lesion consists of a crescentic mass of amorphous eosinophilic substances in the periphery of the capillary loop. Some of them seem to be attached to the inner surface of Bowman's capsule.

Have Separate Origins

The diffuse and nodular lesions consist primarily of mucoproteins with a high content of acid polysaccharides. Bergstrand and Bucht,³ working with the electron microscope, suggest that the two lesions have separate origins, pointing out that the diffuse variety probably arises from thickening of the basement membrane while the nodular one may well be due to precipitation of hyaline material in the cytoplasm of the endothelial cells. This is also the theory of Gellman et al^{5,6} but differs from that of Bell² who stated that nodular lesions develop from the diffuse variety. Bell^{1,2} and Gellman et al^{5,6} stated that nodular lesions are always associated with the diffuse variety, but that diffuse lesions may be found alone. We also feel that the nodular and diffuse lesions are separate entities, probably of different etiology.

Diffuse lesions were present in 75 per cent of the renal biopsies reported by Gellman's group,^{5,6} nodular lesions in 48 per cent. In our series of 19 autopsies and two renal biopsies the diffuse lesion (mild to severe) was seen in 71 per cent — alone in 24 per cent and combined with the nodular type in 47 per cent.

It becomes obvious, therefore, that if diffuse glomerulosclerosis is excluded from the classification of

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glomerular diseases associated with diabetes mellitus, a large number of cases will go unexplained. Kimmelstiel and Porter⁸ have some doubt about the specificity of the diffuse lesion, pointing out the difficulty in distinguishing it from that of chronic glomerulonephritis. Gellman's recent work,^{5,6} however, gives excellent histologic criteria for this distinction, as well as its differentiation from arteriolonephrosclerosis.

There continues to be some question as to how closely the clinical and pathological findings can be correlated. Gellman et al^{5,6} found an association between the clinical picture and diffuse glomerulosclerosis but none with the nodular lesion. They concluded that the "Kimmelstiel Wilson lesion" (i.e., the nodular lesion) is a pathologic entity of diagnostic value but little or no functional significance. This is in opposition to the findings of Dana and Zubrod⁴ who felt that the clinical findings could be correlated with the nodular lesions, but these authors failed to recognize the diffuse variety.

The sex incidence reported by Gellman et al⁶ showed no significant difference. Hall⁷ reported the incidence of glomerulosclerosis to be 1.5 times as frequent in females. Our series showed no significant difference between the two sexes.

Retinopathy and Edema Recognized

As for age, Hall⁷ found the lesions uncommon under 40 years of age, while Mahallowy et al¹⁰ found them uncommon under 30 years of age. Gellman et al^{5,6} found nodular glomerulosclerosis frequently in patients less than 30 years of age. They specifically stated that the incidence is related to the duration of the diabetes rather than to the age of onset. In our series, the combined nodular and diffuse lesion was found in two patients under 30, while the diffuse lesion alone was found in one patient exactly 30 years old. Mahallowy et al¹⁰ feel that the duration of diabetic glomerulosclerosis is important only as it relates to poor diabetic control. In our group of cases, patients with glomerulosclerosis had had diabetes for an average of 5.4 years longer than those who had none. Detailed information concerning diabetic control prior to hospitalization was not always available.

Retinopathy is now recognized as an important associated lesion.⁸ Gellman et al⁶ reported that 60 per cent of 51 patients had it. In our series none of the cases without renal disease had retinopathy while 26 per cent of those with glomerulosclerosis did. It occurred in 30 per cent of those with combined nodular and diffuse lesions, in 20 per cent of those with diffuse lesions alone.

Edema was originally described⁹ as an important feature of the syndrome associated with nodular glomerulosclerosis. Gellman et al^{5,6} stated that the nephrotic syndrome was associated with severe degrees of diffuse glomerulosclerosis but not with the nodular variety. This was stated to be true of edema other than the nephrotic type also. In our series the nephrotic syndrome occurred in no patient without glomerulosclerosis and in two of ten patients with the combined lesions. The occurrence of non-nephrotic edema in our series was not significantly different between diabetics with and without glomerulosclerosis. Kimmelstiel and Porter⁸ feel the nephrotic syndrome occurs in less than ten per cent of the cases of intercapillary glomerulosclerosis. Most authors agree that its appearance strongly suggests glomerulosclerosis in the diabetic.

Proteinuria First Sign

Hypertension is no longer considered an essential part of the clinical picture.⁸ In our cases there was no statistical difference in the incidence of hypertension in patients with or without glomerulosclerosis.

Gellman et al⁶ stated that proteinuria is the first clinical sign of diabetic glomerulosclerosis, 75 per cent of their patients having had proteinuria, often quite intense. Of our patients with glomerulosclerosis, 86 per cent had some degree of proteinuria, 2/3 of them greater than 2+. Of those without glomerulosclerosis only 20 per cent had such proteinuria. Mahallowy et al¹⁰ reported that the incidence of proteinuria varied directly with the duration of the diabetes but that chronicity was important only in the presence of deficient control; they further found no correlation between the severity of the diabetes and proteinuria. Hall's⁷ findings agree with this.

Gellman's group^{5,6} was able to correlate the serum urea nitrogen with the severity of diffuse glomerulosclerosis but not with the nodular form. The average BUN in our group of patients with glomerulosclerosis was 67 mg. per cent, while the average NPN was 61 mg. per cent. In the group without glomerulosclerosis the average BUN was 29 mg. per cent and the average NPN 44 mg. per cent.

No Specific Therapy

At present there is no specific therapy. Until such is found, it seems the better part of clinical judgment to employ reasonable chemical control of the diabetes, maintaining the patient at his ideal weight. A diet high in protein and low in saturated fats should probably be employed. If the patient has already developed far advanced renal disease, those measures usually employed in the control of uremia should then be used.

Summary

There are three types of diabetic glomerulosclerosis; the nodular, the diffuse, and the exudative. The clinical findings correlate best with the diffuse variety. The nodular lesions are considered to be of diagnostic value for the pathologist but can scarcely be dealt with by the clinician. Diffuse and nodular glomerulosclerosis are probably of different etiology. Only one of our patients had the exudative lesion and no conclusions can be reached as to its functional significance because it was accompanied by the diffuse type of change.

Ante-mortem diagnosis is uncertain unless renal biopsy is employed; even with this, the possibility of an uneven distribution of diseased glomeruli exists. The presence of diabetic retinopathy and heavy proteinuria afford strong evidence in favor of the diagnosis. Edema is frequently — indeed usually — absent but the coexistence of the nephrotic syndrome is one of the strongest criteria in favor of diffuse diabetic glomerulosclerosis. Azotemia is also suggestive but certainly not diagnostic. Hypertension is of little or no diagnostic significance. The presence of renal disease in a diabetic with a history of poor control should make one consider diabetic glomerulosclerosis, particularly if the diabetes is of long duration. Certainly the greater the number of these abnormalities which are present in a given patient

with diabetes the more likely does the diagnosis of a specific sclerosing glomerular lesion become.

Talmadge Memorial Hospital

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CENTRAL AUDIOVISUAL FUNCTION ESTABLISHED AT CDC

A central audiovisual function has been established for the U. S. Public Health Service at its Communicable Disease Center in Atlanta.

Formerly the Audiovisual Section, the newly designated National Medical Audiovisual Facility will have responsibility for (1) development, production, acquisition, distribution, and utilization of medical motion pictures and other audiovisual forms; (2) maintenance of the National Medical Motion Picture Archives; (3) dissemination and exchange of scientific and other medical film information important to progress in medicine and public health; (4) encouraging the development and production of medical films and other audiovisuals; and (5) stimulating a speed-up in the circulation of medical knowledge, on a national and international basis, through audiovisuals.

Concerning the role of the newly designated facility, Dr. James Lieberman, director, said, "Communications problems in the life sciences can be met realistically through maximum use of existing national resources. This facility will join with public and private groups in all parts of the nation to help effect audiovisual communications among members of the medical and scientific communities and between these groups and the general public."

Dr. Lieberman emphasized that internationally, as in the past, the facility will give assistance within the limits of its resources. Films will continue to be sent in small numbers to foreign countries where customs regulations do not prohibit shipment. Recently, a study of the international exchange of medical motion pictures was undertaken by the Communicable Disease Center.)

Another recent development was the transfer of the National Medical Motion Picture Archives from the National Library of Medicine in Washington, D. C., to the facility in Atlanta. The Archives will be maintained and enlarged, Dr. Lieberman said, to form a working record of outstanding early and contemporary medical-health films for on-premises screening.

The National Medical Audiovisual Facility is housed in a four story, modern building especially designed for audiovisual activities. The only such installation within the Public Health Service, it houses two stages, a sound recording and reproduction unit, graphic arts and exhibit units, a still photograph reference and cataloguing activity, and motion picture and still photograph processing laboratories.

VITAMIN D — RESISTANT RICKETS

J. Hiram Kite, M.D., *Atlanta* and James W. Harkness, M.D., *Augusta*

- ***This condition will remain incompletely understood until the mode of action and target area of vitamin D and the parathyroid hormone are elucidated.***

THERE ARE SEVERAL METABOLIC disorders which may produce somewhat similar osseous lesions. The vitamin D—deficient rickets which once was prevalent has now almost disappeared. The severe cases of rickets which we see today cannot be controlled with the usual doses of cod-liver oil. For this reason they are referred to as vitamin D—refractory rickets or resistant rickets.

The roentgenographic changes in the bones in these two types of rickets are the same. The changes produced by several other syndromes give similar appearances. These are Fanconi- De Toni- Debre syndrome, renal rickets from chronic renal glomerular and tubular insufficiency, and rickets of celiac disease, and also hypophosphatasia or low phosphatase rickets. Cystinosis gives similar changes in the bones.

Resistant or continued rickets gives the same clinical findings as infantile rickets. There is bossing of the skull, enlarged epiphyses, bending of the long bones, and retarded growth. The children are weak and fatigue readily.

The plasma phosphorus is usually low, the serum calcium is normal or slightly reduced, and the alkaline phosphatase is high.

The radiological appearances can best be studied in the wrists, knees, and costochondral junctions. The ends of the shafts are enlarged and irregular with loss of definition and cupping. The epiphyseal lines become wide. The shafts of the bones become curved with the cortex thicker on the concave side. The vertebral bodies may be biconcave, and the discs biconvex.

This report is based on ten cases seen at the

Scottish Rite Hospital and my office. Only one case will be reported in detail. This patient was followed from the age of three and one half years until he was 22. He died a year later. His last illness and autopsy report will be given by Dr. James W. Harkness of the Medical College of Georgia, who will also discuss the syndromes causing this condition.

This baby was breast fed until he was one and a half years old. Squibb's codliver oil was begun at two months. He took six bottles. The boy did not walk until he was 18 months old. His legs were straight until after he began walking. He was not under the care of a doctor.

At three and one half years he was brought to the Scottish Rite Hospital because he was knock-kneed, emaciated, and small for his age. Breath was taken in through the mouth, the facial expression was dull, and the boy was extremely knock-kneed and flat-footed. The knees crossed in front of each other, and when he stood with knees just touching, the feet were nine inches apart. Genu valgum of 40 degrees in each knee was observed, and enlargement of epiphysis at wrists and ankle was present. X-rays showed that the deformity at the epiphyseal ends of the bones with no bending of the shafts. The metaphysis showed a dense line next to the epiphyseal line and then a line of less density, very suggestive of scurvy. X-rays did not suggest vitamin resistance at the age of three and one half years; in fact, this condition was not known to us in 1940.

The knock knees were treated by braces and during the course of a year were corrected. The deformity relapsed when the braces were discontinued. At the age of six years the epiphyseal lines were wide and there was cupping of the metaphysis

Presented at the 107th Annual Session of the Medical Association of Georgia, May 8, 1961, Atlanta, Georgia.

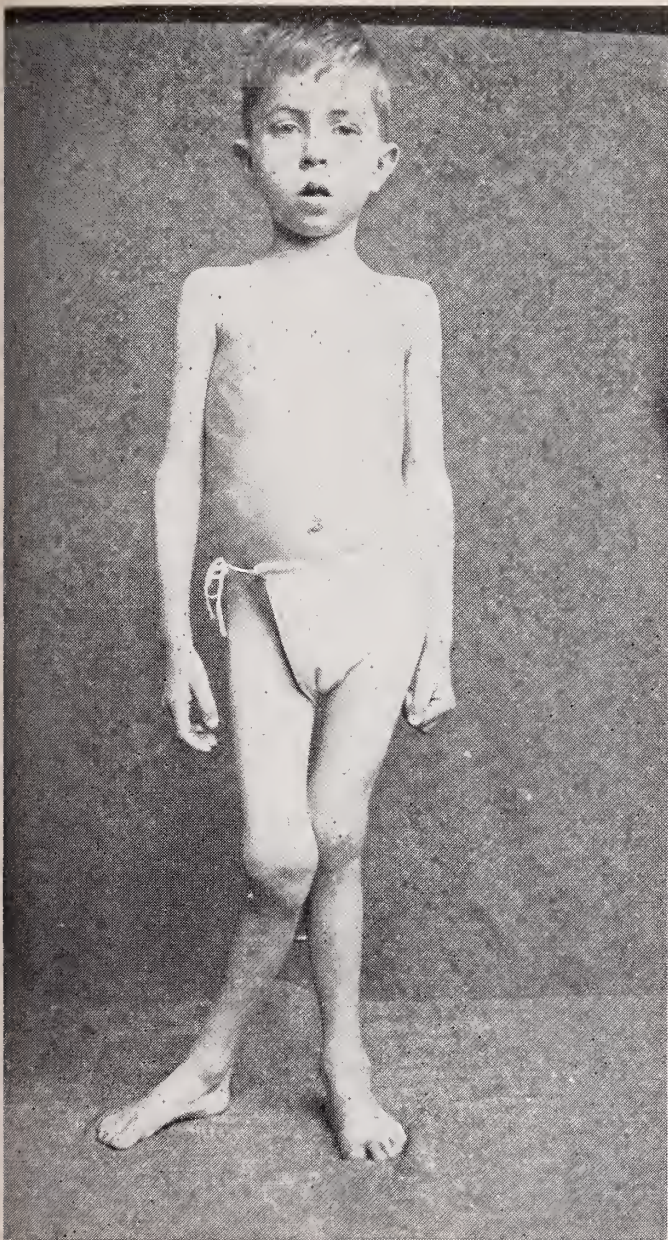


Figure 1

Four year old boy who gradually developed knock-kneed deformity after he began walking at eighteen months. All of the epiphyses are enlarged.

as in rickets. There was marked anterior bowing of the femurs in the lower one third, with osteoporosis and lace-like structure.

One roentgenologist thought this was scurvy and the patient was given large doses of vitamin C for a month with no change in the appearance of the bones. The knock-knee deformity was corrected at the age of six years by high tibia osteotomies. He walked for a while on crutches with his legs straight, and then all of the epiphysis began to enlarge, and he was again fitted with braces because he could walk better with the support they afforded.

At nine he went to school one day without his braces and was pushed down and fractured the left femur. It was a transverse fracture as occurs in osteoporotic bone.



Figure 2

At eleven years he tires easily and can walk only with crutches. The femurs show marked anterior and lateral bowing, as do all of the bones. The enlargement of the ends of the bones is more noticeable.

At that time we thought the best diagnosis might be renal rickets. There was no increase in thirst. The intake and output was measured for five days and the daily intake averaged 1332 cc. and the output 1116 cc. One roentgenologist thought at this time it was renal rickets and another held to scurvy. Another diagnosed it osteogenesis imperfecta.

The patient was studied at Egleston Hospital for eight weeks. I. V. pyelograms showed excellent function. Retrograde pyelograms were normal, Cystoscopic examination negative. N. P. N. 42.8., Calcium 10., Creatinine 1.3., Serum inorganic phosphorous 3.6, Basal metabolic rate plus 29. Blood chlorides 462. Urine showed an occasional pus cell and many phosphate crystals. Their diagnosis was "polyostotic fibrous dysplasia."

The urine on eight admissions to the Scottish Rite Hospital was negative six times and twice showed only a slight trace of albumen.

One year after the fracture of the left femur he fell at school and fractured the right femur. At ten and one-half years he fell and fractured the right humerus. The patient could walk when the fracture healed only with double leg braces and crutches. At eleven he again fractured the left femur, all of the fractures being transverse.

In December 1947, at the age of 11 years he was shown to the Orthopedic Forum and several thought it was vitamin resistant rickets and suggested Ertron. After taking Ertron the wide epiphyseal lines slowly closed, and his general condition improved and he walked better. He was able to walk without braces or crutches. He then had a fracture of the right tibia.

In 1950, after hearing the paper on Vitamin-resistant rickets by Pederson and McCarroll, this patient was put on large doses of Ertron and again the wide epiphyseal line gradually closed, and his general condition improved. When he would discontinue the Ertron for a couple of months, he would get weak again and go back to taking it.

He was seen by me last in July 1958, at the age of 22 years. He was 54½ inches tall and weighted 137 pounds. Head and trunk seemed normal, but the legs were very short and bowed. He was extremely knock-kneed. The epiphyses were fused. The bones showed marked bowing in the shafts, while originally they were straight. Necks of the femurs were very short. Patient was not able to work.

Dr. James W. Harkness

This patient was first seen at the Talmadge Memorial Hospital when he was 23 years old. His chief complaints were extreme muscular weakness and bouts of painful muscle spasms of the hands, legs, and feet. These spasms were alleviated by calcium tablets but had become much worse in the two weeks prior to admission.

He also gave the history of polydipsia, polyuria, and nocturia of six years duration, and sugar had been found in his urine one year previously.

On examination, the patient was stunted, being only 4' 6" tall, and there was marked bowing of the long bones of the extremities and genu recurvatum bilaterally.

Radiographic examination confirmed the skeletal deformities and showed generalized demineralization of the skeleton.

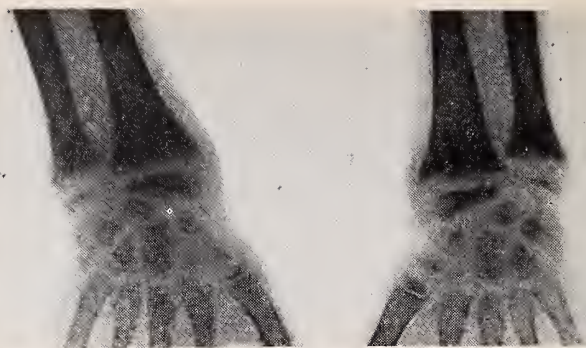


Figure 3
Roentgenogram of the wrists at eight years show wide epiphyseal spaces and the brush like appearances at the metaphysis.



Figure 4
The wrists at twelve years show more increase in the epiphyseal spaces, with atrophy of the bones. The bones are coarse-meshed with thin corticalis. The lower end of the radius shows lines of calcification or remission lines, caused by periods of healing. The diaphyseal ends are widened giving them a goblet shape. There is also some cupping of the ends of the bones. (Ertron was started at this time.)



Figure 5
Wrists at fifteen years and after taking Ertron more or less regularly for three years. The radius has healed better than the ulna. (The epiphyseal lines later fused at the normal time.)

Initial laboratory studies showed some degree of anemia, mild albuminuria, hypokalemia, a reduced carbon dioxide combining power, and hypophosphatemia.

During his stay in the hospital it was found that the attacks of carpo-pedal spasm were precipitated by hyperventilation, but the muscular weakness was

due to hypokalemia. In acute episodes the serum potassium level would drop as low as 1.9 meq/l, and electrocardiograms showed the typical findings of hypokalemia.

The serum calcium varied between 9.2 mg. per cent and 10.2 mg. per cent but was usually under 10 mg. per cent. Serum phosphate varied between 1.5 mg. per cent and 2.3 mg. per cent. In spite of this hypophosphatemia, phosphate was still present in the urine and the T.R.P. was 60 per cent (normal 85.3). In other words, the patient had an increased phosphate clearance. Estimation of the urinary amino acids showed consistently high levels, and the urinary glucose varied from three to 6.5 gm. in 24 hours.

On this basis a diagnosis of Franconi's syndrome was made and confirmed by a renal biopsy.

Treatment was by vitamin D starting with 300,000 units which was increased to 450,000 units/day and potassium supplements. At this juncture the patient was discharged temporarily from the hospital.

Three months later the patient had a severe hematemesis which was found to be due to esophageal varices secondary to cirrhosis of the liver. Although he survived this hemorrhage, a second massive hematemesis occurred six months later causing his demise.

Discussion

Vitamin D resistant rickets is a term which could reasonably apply to any rachitic condition of the skeleton which does not respond to the usual therapeutic dosages of vitamin D. Although this is true of the osteomalacia which accompanies Sprue and the other malabsorption syndromes, this designation is usually limited to conditions where Steatorrhea is not a feature—the so-called “Renal Tubular Rickets.”

In 1952 Dent suggested a classification of these diseases according to the type of tubular dysfunction.

Types one and two fall into the category of “Phosphate Diabetes,” or “Raised Resistance of vitamin D.” The original description by Albright, Butler, and Bloomberg in 1937 was of a case type “1” of Dent's classification. This disease usually becomes manifest in the first two years of life, although cases have been reported where the onset has occurred at puberty or during pregnancy. Type II rickets, where glycosuria is present, has been associated with Von Recklinghausen's neurofibromatosis, and Dent's four cases were all in adults. Fanconi believed that this disease was due to an intrinsic defect in the proximal tubule which impaired the reabsorption of phosphate from the glomerular filtrate and coined the term “Phosphate Diabetes.”

Recent work, however, would seem to disprove this concept.

Steendijk has pointed out that in normal instances phosphate is high when phosphate intake is low, and reabsorption is diminished when the intake is high. When he increased phosphate intake in cases of primary refractive rickets, the T.R.P. was substantially reduced, and when he reduced phosphate intake and minimized intestinal absorption by aluminum hydroxide, the T.R.P. rose to high levels. He concluded that there was a normal reabsorption mechanism in the renal tubules but that the serum phosphate was “set” at a lower level by homeostatic factors in which the parathyroid glands were probably involved.

Infusion Causes Rise

Several papers have shown that infusion of calcium gluconogalactate-gluconate will cause a rise in the serum phosphate level in these cases with a marked improvement, even in normal levels, of the tubular reabsorption of phosphate. This would appear to show that the tubules are quite capable of reabsorbing phosphate and that perhaps the phosphate diabetes is due to a failure of calcium absorption from the gut which in turn stimulates the parathyroids. By raising the serum calcium the parathyroids are “switched off” and the tubular reabsorption of phosphate thereby enhanced.

Dent's type three and four are usually referred to as Fanconi rickets. Glycosuria and amino aciduria are present, in addition to “phosphate diabetes.” Two main syndromes are described, the Lignac Fanconi, which is associated with cystinosis, and the Debre-de-Toni-Fanconi, which is not.

In this type of rickets, from which our patient suffered, pathognomonic changes occur in the kidneys. There is tubular nephrosis without glomerular damage, at least in early cases. The tubules are dilated and their lining cells are flattened or may be swollen with large hypochromatic nuclei. Furthermore, these tubules show marked diminution in alkaline phosphatase activity. Microdissection of the proximal tubules was carried out by Dr. Tom Biggar and I am sorry that photographs of these preparations are not available. However, the proximal tubules were very much shorter than normal, being 1/3 or 1/4 as long. In the proximal portion of the great majority of the proximal tubules the epithelium was very low giving rise to the typical “Swan-neck” appearance.

Some authorities regard the cystinosis as being coincidental while others feel that perhaps the cystine deposits are responsible for the tubular degeneration of the kidney and cirrhosis of the liver

which may also occur, as in our case. This, of course, cannot apply in the de Toni-Fanconi type. However, Woolf and Giles described 27 cases of the nephrotic syndrome in which 25 showed amino aciduria and 16, glycosuria. Hooft and Herpol also described amino aciduria with lipoid nephrosis and felt it was associated with treatment by high protein diet, intravenous protein hydrolysates, or ACTH. They quoted four cases of lipoid nephrosis where tubular dysfunction gave rise to the Debre-de-Toni-Fanconi syndrome. A further two cases were reported by Stickler et al, where the nephrotic syndrome was followed by rickets, glycosuria and amino aciduria. This would suggest that perhaps this tubular damage is acquired and not due to a primary intrinsic defect.

The fifth and sixth types of Dent's classification

perhaps should not be classified as vitamin D resistant rickets and are due to a defect in the distal tubule which prevents acidification of the urine. In some cases there is also a failure of the "ammonia mechanism." This, in turn, leads to hyperchloremic acidosis with loss of calcium and potassium in the urine. The resulting hypocalcemia in turn stimulates the parathyroids with consequent phosphate diuresis.

It is obvious that these diseases are not completely understood and will continue to be enigmas until the mode of action and target areas of vitamin D and parathyroid hormone are elucidated.

In the past, many of these cases of resistant rickets have been diagnosed as osteodystrophy or osteogenesis imperfecta on the basis of the radiologic picture. Such errors can only be avoided by routinely carrying out biochemical investigations in all cases where skeletal changes are seen in the growing child.

490 Peachtree Street

HARTFORD GRANT TO SUPPORT LUNG DISEASE STUDY AT EMORY

Emory University Hospital has received a grant of \$114,172 from the John A. Hartford Foundation, Inc. to continue a study of chronic lung diseases with particular interest in the pulmonary circulation.

The grant will support continued work under the direction of Dr. Osler A. Abbott, Chief of the Division of Thoracic Surgery in the hospital and Associate Professor of Surgery, Emory University School of Medicine.

An original grant of \$193,279 from the Hartford Foundation in 1959 made possible several important developments at the hospital. A lung function laboratory has been developed and staffed with Dr. Allan D. Horres, a respiratory physiologist, as Associate Director.

The lab is used to evaluate lung function, which tells, particularly in patients with cancer, whether they can stand removal of a portion or all of a lung.

The laboratory is used to evaluate a new form of treatment of cancer of the lung, combining radioactive cobalt therapy with surgery. The patients have cobalt treatment before surgery. A complete study of lung function and a detailed study of the circulation of the lung using special equipment is made possible by the grant. The radiation treatment is continued eight weeks after surgery.

In ten of 12 cases treated so far, circulation of the lung has been greatly improved and tumors dramatically decreased in size. The patients subsequently underwent removal of all visible cancer in the chest.

The Emory work is similar to that first done in Sweden and now being done at Emory and in Maryland, Michigan, and Texas in this country. The new methods have been in use at Emory for two years.

The lung function station has helped in treatment of emphysema, the most common disease of the lung in which the lungs become progressively distended until

they have difficulty in supplying oxygen to the blood. The laboratory is used in evaluating treatments.

With the aid of the lung function station and angiographic techniques, Emory doctors have discovered that about ten per cent of emphysema patients can be helped by selective removal of local areas of disease.

The pulmonary angiogram equipment has aided in heart surgery also. The lung function station is being used in the study of all respiratory troubles and has been valuable in teaching, research, and patient care.

The extension of the grant will make possible further studies on emphysema and various types of lung disease.

GEORGIA DERMATOLOGISTS MEET

The Georgia Society of Dermatologists met Sunday morning, May 6, 1962, at Savannah Memorial Hospital to view and discuss 23 unusual and interesting cases collected by the Savannah Dermatologists. At the business meeting, following the discussion of the cases, Dr. Marvin F. Engle, Brunswick, was elected Chairman to succeed Dr. Vincent J. Cirincione, Savannah, and Dr. R. M. Reifler, Macon, was re-elected Secretary-Treasurer. Out of state guests, Dr. Coleman Mopper, Detroit, and Dr. Joseph Farrington, Jacksonville, were entertained at a cocktail party and dance Saturday night at Johnny Harris Restaurant. On Sunday afternoon the guests presented papers at the Dermatology and EENT Joint Section Meeting on "Diagnostic Significance of the Eyelids" and "Misconceptions Concerning Dermatology" respectively in addition to participating in a panel on the "Management of Epitheliomas about the Eyes."

THYROTOXICOSIS: A REVIEW OF RECENT PSYCHIATRIC LITERATURE AND CASE PRESENTATION*

Freerk W. Wouters, M.D., *Columbus*

- *The personality associated with hyperthyroidism tends to be an obsessive one with a frail ego structure.*

THIS PAPER REVIEWS some of the recent work on the psychosomatic aspects of thyrotoxicosis and presents one case, who though admitted with post-thyroidectomy myxedema, presents a number of pertinent findings. Before proceeding to the material dealing specifically with thyroid disorders, some general comments are in order. First, the word "psychosomatic" is taken to imply the study of those factors in the patient's emotional make-up which are necessary for the appearance of a given illness. It may be unnecessary to point out that thus far no such relationship has been rigorously proven for any illness.¹² Secondly, any delineation of such factors needs to include or allow for factors which determine why a given psychologic state gives rise to illness of a structural rather than a functional nature. No hypothesis has been advanced which has gained wide acceptance. A report by Ruesch²⁵ points to some common denominators. He pointed out that these patients present themselves with an arrest of psychosexual development as contrasted to the neurotic group where pathologic development is present. This, however, does not provide adequate specificity since the occurrence of illnesses considered psychosomatic in the course of neurosis has been frequently reported.¹⁸ Furthermore, the personality structure considered associated with hyperthyroidism is a neurotic one. Most writers assume a genetic or constitutional factor in the choice of organ or system involved. This problem has been considered by Kubie,¹⁴ who has pointed out that the choice of symptom within the neurosis is a result of largely accidental factors.

A third problem which has received considerable attention is the problem of how emotional states gain access to endocrine and autonomic expression.¹⁹ Usually a pathway via the hypothalamus is postulated, but limits and conditions of these pathways remain to be elucidated. The converse problem of the influence of hormones upon behavior has been studied, chiefly by experimental psychologists. The data on thyroid hormone, aside from its role in facilitating mentation and activity, is relatively meager.² A final consideration is the problem of recording and communicating of psychiatric data. This is influenced by a host of factors as diverse as the theoretic orientation of the psychiatrist and the social status of the patient. An example of the former would be the different use of the word "hostility" by a psychoanalyst and an operational-oriented psychologist. One would refer to unconscious tendencies; the other, to certain behavioral phenomena.

With these reservations in mind one may proceed to an examination of some of the data referable to thyrotoxicosis. Estimates of the precipitation of Graves' disease by emotional traumata range from 60 per cent to 100 per cent.²² The present concept of the "thyrotoxic personality" represents an evolution of earlier studies, particularly by Mittleman,²¹ Conrad,⁵ and Brown and Gildea.³ The latter authors, however, felt that the traits they observed of suffering in silence, a sense of responsibility, and insecurity were the result of a "constitutional" predisposition. Ham, Alexander, and Carmicheal¹⁰ in 1951 formulated the essentials of the current concept in six points:

*Based on a paper delivered at a Symposium, "The Thyroid," held at the Medical College of Alabama, Birmingham, January, 1960.

1. A premature need for self-sufficiency and maturity in taking care of self, parents, and siblings resulting from one or more of the following: (a) inadequate parental support due to either death, divorce, or economic stress; (b) multiple siblingship with a significantly high incidence of the patient being the oldest; or (c) traumatic exposure to significant death episodes.
2. An inability to express hostility.
3. A struggle against fear by denial, repression, and counterphobic attitudes.
4. A lifelong ambition toward advancement.
5. A significantly greater than average urge to bear children.
6. Frequent, spontaneously presented, effect-laden dreams of death, caskets, etc.

Observations Formulated

These observations were formulated into the following picture. The patient who develops thyrotoxicosis was exposed early in life to traumata with resultant insecurity and fear of death which could not be allayed by gratification of dependent needs. The patient responded with a desperate attempt to attain maturity and self-sufficiency prematurely. This drive is considered the unique aspect of these patients' personalities. It leads to a repression of their dependency strivings and their hostility, which along with intellectual limitations, prevents an adequate integration. The common denominator of the various stresses is considered the threat to, or actual dissolution of, a relationship from which the patient was obtaining some satisfaction for his dependent needs. Lidz¹⁵ pointed out that it is the activation of hostile impulses which the patient feels (unconsciously) must never be expressed which gives rise to the most obvious clinical findings. These include depression, phobias, reaction formations, etc. Two comments may be made with reference to the foregoing. The finding that the patient is the oldest is certainly not uncommon in psychiatric studies, for instance the schizophrenias. Secondly, the data on children born to patients with thyrotoxicosis has been challenged by Mandelbrote and Wittkower.²⁰ They also questioned the specificity of the personality type and pointed out that many patients with a similar make-up show no evidence of thyroid disorder. Lidz^{15,16,17} has emphasized the role of hostile impulses and has also stressed the severe threat to the patient's equilibrium posed by events usually not considered traumatic. He reported a series of eleven consecutive patients who had thyrotoxicosis associated with pregnancy. He felt that in these patients the finding

of significant emotional traumata would be less likely since the physiologic alterations occurring during this time might well account for the appearance of the disease. He, however, found a severe emotional disturbance as a consequence of the pregnancy and concluded, "The finding that threats to emotional equilibrium are operative in patients whose Grave's disease had its onset in relation to pregnancy, greatly increases the probability that emotional disturbances play an essential role in the etiology of hyperthyroidism."¹⁷

A number of psychophysiologic studies have been done attempting to correlate psychologic stress and thyroid function. Hetzel, de la Haba, and Hinkle¹¹ reported a rise of the PBI up to 100 per cent over three to seven hours following stress interviews. Reiss *et al*²³ using radioactive iodine uptake as an index of thyroid function reported studies on over a thousand patients in a mental hospital and felt that in 60 per cent of female patients thyroid hyperactivity was present which could be correlated with an "objective anxiety state." Other studies have failed to support this, most representing contradictory findings.^{9,13} Dongier, Wittkower, Stephans-Newsham, and Hoffman⁶ were unable to repeat the studies of either Hetzel, de la Haba, and Hinkle or Reiss *et al*. They, however, restated the findings of Carmicheal, Alexander, and Wittkower to include the emphasis on hostility by Lidz and added that a feminine identification occurred in male patients. Using these criteria they predicted correctly in 34 of 44 patients whether they would show a biologic half of life of I-131 less than or over 45 days. The result is significant to a level of less than .001. They did not make any statement as to the exclusion of patients with patient family history of Graves' disease.

Correlations

Over-all, these studies have demonstrated a correlation of a personality pattern with thyrotoxicosis. The significance of this correlation remains to be determined. A number of other correlations might be hypothesized. For instance, a higher incidence of functional psychosis in post-thyroidectomy myxedema as compared to spontaneous myxedema might be investigated. On review of the records at the Birmingham Veterans Administration Hospital, we were able to find only 11 cases falling in one or the other category and few were seen by psychiatrists. Nevertheless, four of six cases of post-thyroidectomy myxedema had a psychiatric diagnosis recorded on discharge, while none of the spontaneous or post-thyroiditis group had one recorded.

A word needs to be said about the psychosis associated with myxedema. In general, the work of Engels and Romano^{7,8} demonstrates that the psychi-

atric findings in myxedema, which occur in all cases, is a difficulty in mentation common to most endocrine hypofunction states. This reduction correlates with the level of awareness and laboratory findings appropriate to the disease in question as well as non-specific slowing of the EEG in these states. The work on myxedema has received independent confirmation from Reitan,²⁴ who studied myxedematous patients by projective techniques and found the pattern approached the organic psychoses where loss of neural tissue had been demonstrated.

Phobias Reported

These findings are also in accord with earlier writers^{1,27} who distinguished between the slowing, lethargy, and the coincident functional states. These latter have been of a wide variety, although paranoid states seem to be reported most frequently. The occurrence of phobic states is generally not mentioned, though the Report of the Committee on Myxedema of the London Clinical Society specifically mentions agoraphobia in a number of cases.⁴

W. W. is a 37-year-old, married, Caucasian floorfinisher of limited intelligence who was admitted to the Birmingham Veterans Administration Hospital with a chief complaint of "I'm afraid of everything." The present illness had begun about three years prior to admission when, after the sudden death of an elderly boarder in the house where the patient was living, he became "nervous" and preoccupied with thoughts of death. He would comment on the obituaries in the paper and wonder when his time was coming. He consulted numerous physicians and hospital outpatient clinics, going so far as to spend the night in his car outside hospitals so that he would be near help when he had his coronary. After about one year when he had lost 50 pounds weight and had developed heat intolerance, he consulted a cardiologist who made a diagnosis of thyrotoxic heart disease and referred him for thyroidectomy. This was done 22 months prior to admission. After surgery the family noted little change in his preoccupations, though he was less active and regained some of the weight he had lost. He continued to operate his own business until several months prior to his admission when a close friend about his own age died suddenly of a myocardial infarction. After this the patient would not leave the house unless accompanied by his wife. He was unable to say what he was afraid of. He became worried about the weight he had regained and began to refuse foods which he had read in the paper were bad for people. This resulted in a rather limited diet. He became more lethargic shortly prior to admission, became impotent, and lost weight.

Upon admission he was a mildly agitated individual who displayed moderate psychomotor retardation but denied depressive affect. He was preoccupied with various morbid subjects and repeatedly requested reassurance that he was not about to die.

The past history was quite revealing. His father had deserted when the patient was about two. The mother remarried when the patient was about eight to a man the patient was quite attached to. He also deserted when the patient was twelve. The mother is an extremely tense, anxious woman, who hovers about the patient and inquires incessantly about his health and whether he is going to recover. She had a psychotic episode shortly prior to her second marriage and was treated with "shock treatments."

The patient was the middle of three siblings. No unusual developmental difficulties are recorded. He was quite nervous and hyperactive when he reached school age and refused to sit through classes. "I would beat my mother home when she carried me." He was allowed to quit school with the consent of the school authorities at age 14. He then learned the trade of floor-finishing and was able to conduct his own business as a subcontractor for this work in spite of his limited intellectual abilities. He married at age 19 after a brief courtship and has two children to whom he is indifferent. His wife has had to assume all responsibilities outside his work, including seeing to it that he got haircuts, bought clothes, shaved, etc.

The patient's hospital course was a stormy one with the appearance of a paranoid psychosis when he was restored to a euthyroid state. He finally was able to leave the hospital.

In summary, the psychiatric literature indicates that the personality associated with hyperthyroidism is an obsessive one with a frail ego structure. A case has been presented illustrating some of the features involved.

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PROGRESS REPORT ON MEDICAL SELF-HELP TRAINING

Legal responsibility for Civil Defense Health Services in Georgia lies with the Director of the Georgia Department of Health. In his capacity as Director of this service he has assigned implementation of the Medical Self-Help Program to the Deputy Director of Civil Defense Health Services. The Deputy Director is assisted by a Medical Self-Help Committee made up of representation from the Medical Association of Georgia, the State Department of Education, the Red Cross, the Medical Auxiliary, the Office of the State Director of Civil Defense, and the Health Education and Training Service of the Georgia Department of Public Health. With the advice and assistance of the above Committee, the Deputy Director of Civil Defense Health Services assumes program responsibility in the name of the Director of the Georgia Department of Public Health. The program is administered from the offices of the Georgia Department of Public Health.

Narrative reports from the District Health Directors of Georgia would indicate that at least 21 of the 25 Medical Health Officers are at this moment actively promoting Medical Self-Help Training. This includes the Medical Director of the Hall-Banks Health Department which is not under District direction. The letters further indicate that local situations are such in three of the remaining four areas to contraindicate immediate implementation of the program but that plans are being made to start training programs at some near future date.

Prior instruction to instructors has varied from one area to another. Local conditions, largely dependent on the background of potential instructors, have dictated need or lack of need of prior instruction for instructors about to begin teaching the course.

Medical Health Directors, School Administrators, Public Health Nurses, local medical practitioners, parent groups, and home demonstration agents are among those who have actually participated in recruitment in Georgia.

Generally speaking, local control and administration of the program in Georgia seems fairly good. However, we do wish that more use was made of Local Commit-

tees, particularly in interpreting to communities and individuals the basic purpose of the program.

Through the assistance and cooperation of our Georgia Civil Defense Advisory Committee, we have been fortunate in having participating assistance from Civil Defense, Health Department, School System, Red Cross, County Medical Societies, P.T.A.'s, Industries, and Youth Groups in promoting the Medical Self-Help Program.

We have assigned one kit each to Milledgeville State Hospital, Battey State Hospital, and Gracewood State School and Hospital. Supervising attendants at these three institutions will take the Medical Self-Help Training Course and will thus be able to meet emergency situations which might arise in the event of disaster, particularly if the disaster occurred at a time when few, if any, of the institutional medical staff was present. We feel that such training is most important for institutions such as these where mental, tuberculosis, and retarded patients are housed. We would also like to eventually be able to offer the training to certain personnel of the prisons of our State.

We consider our program plans in Georgia as being adequate to meet the enunciated five-year goal. However, to do this we do need assurance of necessary supplies and we need our people convinced that this program has top-level priority. We cannot do more than implement the program; the needed assurance of program priority must come from the Federal level and must be bulwarked by a continuing aggressive and well-defined intent of continuity. We can make little progress on the local level with a program that alternately "blows hot" and "blows cold" at the Federal level.

Generally speaking this is a good program "for the people and by the people." It should be kept so. Top level approval and encouragement are essential, however, the people should be encouraged to "do it yourself." This was the original concept of the program and we should not depart from it.

*Lester M. Petrie, M.D.
Disaster Medical Care Committee*

ROLE OF CHLORDIAZEPOXIDE* IN DERMATOSES

Sidney Olansky, M.D., and Marion Olansky, M.D.**, *Atlanta*

■ *In experience with 127 patients, this new medication appeared to be a safe, reliable, and valuable agent in the treatment of a wide range of dermatoses.*

THE EMOTIONAL COMPONENT in dermatoses and skin allergies is a constantly mounting problem. As specialists in dermatology (S.O.) and pediatric allergy and dermatology (M.O.), the authors find an increasing proportion of their patients with this type of difficulty.

The dermatologist often finds himself forced to treat a dual disease, stress and skin disease. In situations where psychiatric services are not readily available or feasible, the emotional side of the disease must be dealt with largely by chemotherapy.

Here, as Robinson has pointed out,¹ the choice of agents is relatively limited. The rauwolfia derivatives are contraindicated for the protracted therapy needed in most dermatoses. Sedatives and sedative-stimulant mixtures are effective only in mild anxiety and tension states. Meprobamate and the phenothiazines are more often helpful in breaking the vicious circle of skin-psyche deterioration — though always with the possibility that these agents may introduce a third untoward factor: toxicity.

In our clinic we have used a wide variety of ataractic drugs, especially such phenothiazines as Temaril, Atarax, Compazine and Thorazine. Our need for psychotherapeutic agents led us to try the new drug chlordiazepoxide soon after it was introduced in the spring of 1960. This is the first tranquilizer to exert a powerful effect upon tension and anxiety without clouding the sensorium and the brain, and with a minimum of side reactions.²⁻⁷

So far chlordiazepoxide has been most widely used in psychiatry, and few reports have been published of its use in dermatology. McGovern, et al⁸ have evaluated this agent in allergic patients, including those with skin allergies. They found it effective in

45 of 50 allergic children and in 102 of 114 private patients of all ages. The dermatoses falling into this study were urticaria, eczema and hyperhydrosis, in all of which the clinical response was excellent. Robinson¹ not only studied chlordiazepoxide in 177 patients with a variety of skin ailments, but compared its patient acceptance with meprobamate, buclizine, and a barbituric acid derivative. In both areas the results were highly favorable to the new agent; the patients preferred chlordiazepoxide to the other drugs in a ratio of 115 to 47.

In the present study we attempted to evaluate chlordiazepoxide in a series of 127 patients, including a large group of persons with a diagnosis of neurodermatitis. Incidentally, the study offered a chance to observe the extent of the placebo effect in the therapy of dermatoses.

Method

A selected series of 128 patients was used in the study. Roughly two-thirds had diagnoses of neurodermatitis, seborrheic dermatitis, psoriasis, dyshydrotic eczema or acne vulgaris. The group included 93 females and 35 males ranging in age from 18 months to 82 years. The age groups were as follows:

1½ to 11 years	6
12 to 19 years	14
20 to 29 years	36
30 to 39 years	26
40 to 49 years	19
50 to 59 years	17
60 to 69 years	7
70 years and over	3
	<hr/> 128

Since one purpose of the study was to determine the extent of placebo effect in a group of this kind,

*Librium, trademark of Hoffmann-La Roche, Inc., Nutley, N. J.
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identical capsules were prepared, containing chlordiazepoxide or placebo. The 5 mg. capsules used in the pediatric patients were labeled K and S, and the 10 mg. dosage A and B. The placebo, B or K, was first administered to the patient for one week or sometimes two weeks, and its clinical and subjective effects were recorded. The patient was then put on the active drug for the remainder of the test period, and again changes in symptomatology and subjective responses were noted. In the case of young children, their parents and teachers often supplied information about changes in attitude and general well-being noted under drug therapy.

Whatever topical therapies were indicated for the treatment of a given skin disease were continued during administration of the placebo and chlordiazepoxide.

Children were given a dosage of 5 mg. t.i.d. or q.i.d., and adults twice that amount, the great majority receiving 30 mg. a day in three doses. In a few cases the dosage was revised upward from 30 to 40 mg., but most patients were maintained successfully on 10 mg. t.i.d. If drowsiness occurred the noon dose was omitted. Towards the end of the test period, when patients had been on chlordiazepoxide from two to four months, it was often found that a bedtime dose of 10 or 20 mg. was sufficient to keep the patient stabilized; and others used chlordiazepoxide only as needed, during periods of special stress.

Duration of chlordiazepoxide therapy ranged from one to four months, with the majority of the patients under medication for at least two months when the report was made. Stubborn and chronic cases responding well to the drug are still being continued on minimal effective dosage schedules.

All patients had urine tests and complete blood counts before the initiation of chemotherapy, and a month after medication began.

Results

Only one patient, with a diagnosis of angioneurotic edema, failed to return for follow-up. The results of chlordiazepoxide therapy, presented in Table I, thus concern 127 patients. Of these, 115 (90 per cent) showed improvement of psychic or somatic conditions, or both, and this relief of symptoms was distinctly good or excellent in all but half-a-dozen patients. Response to the placebo was noted in only 19 cases (15 per cent), and it was slight in 17 instances.

In general, those patients who were benefited by

the placebo were helped more by chlordiazepoxide. In only two cases were patient reactions equally good to the placebo and the active drug. In one, a male aged 58 years with neurotic excoriations, there was no real difference in response to capsules A and B. The other case was a female aged 27 years with seborrheic dermatitis whose skin condition improved during the two weeks she was taking the placebo along with local therapy. There was no improvement in her psychic symptoms, however, until she was switched to chlordiazepoxide, which afforded her considerable help. The subjective reactions to the two agents were definite; many patients reported that chlordiazepoxide A (the active medication) was decidedly better than chlordiazepoxide B, and only two decided that it was "a little better." One patient, diagnosed by a psychiatrist as a schizophrenic, claimed that the chlordiazepoxide B (placebo) made him sleepy.

Patients Benefit

Nine out of every ten patients in the series received tangible benefit from chlordiazepoxide therapy, most of them experiencing relief both of tension and of skin symptoms, especially itching. Of the 30 neurodermatitis patients, results were excellent in 11, good in 16, fair in two and poor in only one. All 15 of the acne vulgaris patients showed improvement, as did all the lichen planus and dyshydrotic eczema cases. The drug was effective to some degree in all types of dermatoses in the series except for neurotic excoriations and pruritus ani or vulvae.

In some instances skin conditions improved while the underlying emotional disturbance apparently remained untouched; more often both emotional and physical symptoms were relieved. A boy aged seven years with dyshydrotic eczema of the feet associated with secondary infection had frequently developed a sudden vesicular eruption of the soles after a tense period. On chlordiazepoxide five mg. q.i.d. he itched much less and developed fewer vesicles, as long as he was on the drug. The clear connection between chlordiazepoxide medication and improvement of symptoms was noted in many patients who were taking the drug off and on. A woman aged 38 years with chronic urticaria believed to be of emotional origin became worse both in psyche and skin whenever she temporarily discontinued chlordiazepoxide. Another woman aged 33 years with acne excoriée and severe emotional problems, has been on chlordiazepoxide therapy intermittently for four months, on a dosage of ten mg. t.i.d. Though she now feels she "can't get along without chlordiazepoxide" her condition continues to improve and she has developed no side effects.

Perhaps the most frequent effect of chlordiazepoxide therapy has been the relief of itching,

especially at night. Many of the patients have declared that chlordiazepoxide is the best sleeping tablet they have ever had; they wake refreshed with no hangover.

No toxic effects were observed during the 4 months' trial period; blood counts and urinalyses remained normal. Twenty patients became drowsy, but in only one was chlordiazepoxide discontinued for that reason. In the others the sleepiness wore off without reducing dosage, or ceased when dosage was reduced. The only other side reaction was depression in two cases. One was a woman aged 30 years with housewife's eczema, who made two trials of one week and then two weeks with chlordiazepoxide 10 mg. t.i.d. and finally discontinued medication. The other was a woman aged 45 years with severe neurodermatitis associated with a secondary infection. This patient has grave psychiatric problems and all psychotropic agents depress her. Besides the three patients who discontinued chlordiazepoxide because of side effects, two others dropped medication because it had failed to help them: the diagnoses were neurotic excoriations and psoriasis.

It was noteworthy that no cutaneous reactions to chlordiazepoxide were noted, nor were there instances of overexcitement such as occasionally occur with phenobarbital or with chlordiazepoxide itself.⁹

Summary and Conclusions

A series of 127 patients with a variety of dermatoses characterized by emotional components were treated in blind fashion with a placebo and with chlordiazepoxide. Fifteen per cent showed a relatively mild response to the placebo, but while under chlordiazepoxide, 90 per cent of the same patients demonstrated clear relief of tension and anxiety and/or somatic symptoms.

Thus the placebo effect, in this study, was less conspicuous compared with the reported experience of others. The placebo effect has been generally interpreted as an indication of the unreliability of clinical trials in patients who exhibit hypochondriasis of a superficial kind that is readily influenced by mere suggestion. It would seem from our experience that, on the contrary, we are very often dealing with patients in real need of psychiatric or chemotherapeutic help. The potency of chlordiazepoxide in obtunding emotional symptoms seems to explain why the placebo, both subjectively and objectively, was so markedly less effective. In our hands, chlordiazepoxide appeared to be a safe, reliable, and valuable agent in the treatment of a wide range of dermatoses.

It is to be hoped that further study will be undertaken to evaluate the placebo effect in the dermatoses and other disorders in which emotional factors are implicated. It is suggested that one method of mak-

ing such an evaluation is the technique of comparison with the active drug in the same patients who are unaware of the nature of the medication prescribed.

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Emory University School of Medicine

Table I
Effects of Chlordiazepoxide and Placebo
in 127 Patients

DIAGNOSIS	No. CASES	LIBRIUM		PLACEBO	
		Imp.	Not Imp.	Imp.	Not Imp.
Neurodermatitis	30	29	1	5	25
Acne vulgaris	15	15		1	14
Seborrheic dermatitis	14	13	1	2	12
Psoriasis	11	10	1	3	8
Dyshydrotic eczema	9	9		2	7
Lichen planus	6	6		2	4
Eczema	9	7	2		9
Acne excoriée	3	3		2	1
Seborrhea	3	3			3
Chronic urticaria	3	2	1		3
Anxiety states, with dermatologic symptoms	3	3			3
Rosacea	2	2			2
Pruritus ani or vulvae	2		2		2
Lichen simplex chronicus	2	2			2
Neurotic excoriations	2		2		2
Hyperhydrosis	2	1	1		2
Various dermatoses*	11	10	1	2	9
TOTALS	127	115	12	19	108

*Single cases of verruca, ichthyosis, leukemic pruritus, generalized pruritus, exfoliative dermatitis, alopecia, keratosis, porphyria cutanea tarda, aphthous stomatitis, nummular eczema and mycosis.

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EPIDERMOID CYST OF THE SPLEEN

V. W. McEver, Jr., M.S., M.D., and Horacio Paparelli, M.D., *Atlanta*

■ ***The twenty-fifth reported case of
this rare condition is presented***

EPIDERMOID CYST OF THE spleen is a rare lesion. Twenty-four cases have been recorded in the literature since the first was reported in 1929.¹ The most frequent cysts of the spleen are the pseudocysts, such as those resulting from trauma, inflammation and degeneration. This case, according to Fowler's² classification of non-parasitic benign cysts, represents a true cyst of the spleen. Other cysts in this group are lymphangiomas and hemangiomas.

Splenic cysts are found during the first four decades of life,² rarely afterwards. The greatest incidence of epidermoid cysts is in the 20-30 age group. Sixty per cent of them occur in females. Epidermoid cysts represent less than ten percent of all the cases reported in the medical literature.

The etiology of this tumor has not been proven but many possibilities have been proposed. Probably the most plausible is, that they originate as "embryonic anomalies of mesodermal cells."³

The symptomatology is usually vague. The clinical diagnosis may be difficult. The signs and symptoms appear dependent upon the degree of compression of contiguous viscera.⁴ Only one-half of the recorded cases had demonstrable splenic enlargement. Others had vague complaints related to the gastrointestinal or respiratory tracts. X-ray studies with contrast media showing organ displacement may be the only positive finding.

Case Report

A 21-year-old white female was admitted to the hospital in February 1960, with a complaint of pain in the left upper quadrant of the abdomen. She had begun having generalized abdominal discomfort in October 1959. X-ray studies at that time, with contrast media, revealed a non-calcified mass in the left upper quadrant of the abdomen producing displacement of the gastrointestinal viscera.

Gradually the discomfort increased and localized in the left upper quadrant of the abdomen. Her discomfort was markedly aggravated by sitting long hours at her desk as a typist. She began having episodes of nausea. Her appetite was good but shortly after beginning to eat, she would develop a sensation of fullness. Due to increasing discomfort, she consented to surgery.

Surgical exploration was carried out through an upper left paramedian incision. The spleen, with a cyst occupying the entire lower pole, was removed without difficulty. The post-operative course was uneventful and the patient was dismissed on the sixth post-operative day. The patient has had no symptoms since the operation.

Pathology

Gross: The specimen consisted of a spleen which measured 18 cm. x 15.5 cm. x 11 cm. A single cyst, 12 cm. x 7.5 cm., occupied the lower two-thirds of the external surface of the spleen. The spleen appeared to be compressed by the cyst. The external surface of the cyst was yellowish-green, glistening, and thin-walled in the center. There was a tannish mottling with old hemorrhage around the periphery of the cyst lining. A clear yellowish-green fluid was seen inside the cyst. The cyst was opened and 300 cc. of yellowish-green fluid was found. There were prominent trabeculae in the wall formed by the splenic parenchyma. The lining between the trabeculae was smooth, dark-red in color. The spleen otherwise was normal and weighed 175 grams. On cut section, the parenchyma appeared normal.

Microscopic: Sections of the spleen and cyst show the cyst to be lined with stratified squamous epithelium with underlying dense connective tissue and no skin appendages.

Diagnosis⁵: Epidermoid cyst of the spleen.

Summary

Epidermoid cysts of the spleen are rare. This report represents the twenty-fifth recorded case. Clinical diagnosis is difficult. The symptomatology is vague and is due to compression effect on adjacent viscera. X-ray studies with contrast media showing organ displacement may be the only definite finding. The treatment is splenectomy.

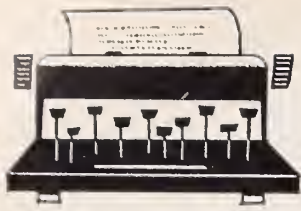
St. Joseph's Infirmary

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NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

Name	Address	Classification	County Society
Achord, James L.	69 Butler St., S.E. Atlanta 3, Ga.	DE 2	Fulton
Alperin, Herbert	1865 Joseph Court Decatur, Ga.	Active	DeKalb
Bateman, John D.	912 Sixth Avenue Albany, Ga.	Active	Dougherty
Boddy, A. Evan	1968 Peachtree Rd., N.W. Atlanta 9, Ga.	DE 2	Fulton
Dellinger, Ray E.	1526 Shoup Court, Apt. 2 Decatur, Ga.	DE 2	Fulton
Donnelly, Elwin W.	300 Boulevard, N.E. Atlanta 12, Ga.	Active	Fulton
Hall, David P.	Medical College of Georgia Augusta, Ga.	Active	Richmond
Lear, Thomas F., Jr.	35 Linden Ave., N.E. Atlanta 8, Ga.	DE 2	Fulton
Lemley, John W.	Doctors Bldg. Thomson, Ga.	Active	McDuffie
Lowry, Thomas F.	2646 Gresham Rd., S.E. Atlanta 16, Ga.	Active	DeKalb
McCormick, Glenn E., Jr.	Box 459, Emory University Clinic Atlanta 22, Ga.	Active	DeKalb
McNeil, Jesse N.	699 Ponce de Leon Ave., N.E. Atlanta 8, Ga.	DE 4	Fulton
Miller, H. E.	111 Ryon Street Hinesville, Ga.	Active	Tri County
Murray, Darrell W.	4228 Old Powder Springs Rd. Mableton, Ga.	Active	Cobb
Palay, Bernard H.	4158 Peachtree Rd., N.E. Atlanta 19, Ga.	Active	Fulton
Smith, Richard A.	384 Peachtree St., N.E. Atlanta 8, Ga.	Active	Fulton
Thomas, Charles B.	Talmadge Memorial Hospital Augusta, Ga.	DE 2	Richmond



Tragedy in Paris

ON JUNE 3 THE entire world was stunned at a news bulletin from Paris. The bulletin described the tragic crash of a chartered trans-Atlantic airliner with 131 persons aboard. Only two stewardesses survived the fiery crash, which occurred on takeoff. It was subsequently learned that the airplane described was carrying a party of Atlantans—all members of the Atlanta Art Association, returning home after a three-week tour of the art centers of Europe. While news commentators described the crash as the worst catastrophe in the history of commercial aviation, they could not describe the unbelievable sense of shock which descended over Atlanta and its environs. Among the 121 victims from the Atlanta area were many of the professional and cultural leaders of the city. It has been estimated that no major city in America has lost so many of its leaders in any single catastrophe.

Among the victims were Dr. and Mrs. Christopher J. McLoughlin. Dr. McLoughlin served the Medical Association of Georgia as Secretary during the years

1957-60. He worked tirelessly in this office and was largely instrumental in negotiating the purchase of the beautiful Headquarters Office Building which the Association now occupies. Also among the passengers was Mrs. Marion Benson. After hearing of the tragedy, Dr. Benson, an obstetrician and gynecologist in Atlanta, suffered a cerebrovascular accident, from which he succumbed three days later. The widow of Dr. Marion Pruitt was among those in the crash. Dr. A. P. McDonald, a dentist, and brother of Dr. Harold McDonald, perished along with his wife. Mrs. Henrietta Collier Ayer, wife of Dr. Darrel Ayer, a pathologist in Atlanta, and Mrs. T. L. Tidmore, widow of the late Dr. Tidmore, were also in the crash.

Atlanta and Georgia will not soon recover from this great shock and loss of so many of its beloved relatives and friends. The *Journal* wishes to express the most sincere sympathy to the families and loved ones of those departed from us in this untimely tragedy.

Georgia's Medical Assistance to the Aged Program

THE PROBLEMS OF a new program can never be completely anticipated. The noble and foresighted Legislators who enacted the Kerr-Mills law must have been thinking only of those they intended to benefit when they wrote into the law a clause that required every eligible recipient to be notified of his eligibility. They probably visualize the poor elderly person lying in a lonely bed, not knowing of the wonderful blessings of multiple shots and cold bed pans awaiting him in the hospital. One cannot but wonder if they visualize the busy, perspiring doctor facing an irate family, led by Granpa clutching a notification slip demanding that he be allowed to enter the hospital to determine why his old miseries are kicking up lately . . . and besides he needed the rest. This seeking of unnecessary services by eligible recipients has been the greatest single cause of complaint since the program began.

The doctors of Georgia have steadfastly stood their ground. They have refused repeatedly to compromise necessity for convenience, thus there has been no over-utilization. This fact, and this fact alone, has enabled the MAA Program to expand in so short a time. The limited funds available may be used to add needed services to the program.

The first expansion of Kerr-Mills Program in Georgia is now effective, and it is time to begin thinking ahead. What illnesses should be included? Should a drug program be started? How much would it cost? These and many other questions will need answers in the near future. The Medical Association of Georgia is an advisor to the Welfare Department in these matters, thus it is the right and privilege of any member to make constructive criticisms of the program and these suggestions are encouraged.

Knowledge of Aviation Medicine

Stressed in Modern Times

Travel by air is increasing rapidly. This includes private flying, corporate flying, and travel by commercial planes. More people are involved in flying, either as passengers or crew members. Thus, it becomes increasingly important for the private practitioner to learn some of the facts of Aviation Medicine.

There is a great deal of difference in flying as a passenger and in flying as a crew member. The literature concerning the contraindications to flying as a commercial passenger is extensive. In general, there are only a few conditions that preclude air transport of patients. Patients with dental conditions necessitating the wiring together of the jaws, cardiac decompensation, and respiratory distress are illustrations of this group.

The number of private planes and corporations owning executive planes is increasing. This means that industrial physicians and private practitioners will be treating more and more air crew members. These physicians should become familiar with drugs that cannot be given and permit the crew member to continue flying. For various reasons the following drugs necessitate the grounding of an airman taking them:

***	Amebicides	Anticonvulsants & C.N.S.
	Analgesics	depressants
	Anthelmintics	Antihistaminics
	Antiarthritics	Antimalarials
	Antiasthmatics	Antiprotozoans
	Antibacterial Agents	Antipyretics
	Antibilharzials	Aniline Series
	Antibiotics	Antispasmodics
	Anticholinergics	Antisymphilitics

***The list of drugs is taken from one prepared by the Airline Medical Directors Association.

Antithyroid Drugs
Cardiovascular Agents
Narcotics
Oxytocies

Sedatives
Skeletal muscle relaxants
Tranquilizers

Private practitioners who administer drugs to airmen should caution the airman to clear through his Flight Surgeon or Company Physician before resuming flying activities. Owners of private planes should be advised not to fly until the physician is positive that there are no effects of medication remaining.

For example: There was a pilot who was given streptomycin and penicillin for sorethroat. He was told by his family physician that he could continue to pilot a plane. Streptomycin has been known to cause vertigo by its effect on the middle ear. This could have resulted in an airplane crash.

Frequently airmen with a slight upper respiratory infection take "cold capsules" containing atropine. These may be prescribed by a physician or purchased over the counter. At high altitudes sunlight may be very bright since there is no ground haze to cut down light rays. The atropine may interfere with normal constriction of the pupil. Serious visual difficulties may result.

These are illustrations of the many ways that the indiscriminate use of drugs may result in an unnecessary hazard to the pilot.

The modern plane is a highly complicated machine. It takes a high degree of skill, and intense concentration to pilot these planes safely. All physicians should be extremely cautious to avoid prescribing drugs that may interfere with these skills or concentration.

J. E. Griffith, M.D.

WHY IS THAT DADDY?

Several months ago I spent one of those rare delightful evenings, when my son and three of his friends chose to remain at home and chat with the old man.

The boys had finished their freshman year in college. They had bought a used station wagon and had just returned from a summer's work in Oregon. The months of June and July were spent working in a plant that devoted its efforts, 24 hours daily, seven days a week, to freezing green peas.

It seems that when the peas are ready to be harvested and frozen there is little dilly-dallying—they must be harvested and frozen, or they become unfit for home or banquet consumption.

These boys had no trouble getting a job—they worked 12-hour shifts and sometimes seven days a week. When the season was over the boss asked them to return next year. They made good money, but were shocked at the payroll deductions.

Three of the boys finished their work about a week sooner than the fourth. Having nothing to do they went to an employment agency and requested temporary work. Much to their surprise they got a call that night

to report by bus to some nearby town in the mountains to fight a forest fire. The forest ranger had called for 15 men. They all arrived and had the fire out in some eight to ten hours of hard physical work. Then another 12 to 15 hours were spent eliminating, "knocking out," stumps and logs.

The boys noticed that after the fire was out, the remainder of the 15 men worked on the smoking stumps only when the boss ranger was around—otherwise they stood and talked. They learned that most of these men were drawing unemployment insurance and had been for weeks. Many of their wives were drawing it also. This was the chief topic of conversation.

The boys could not understand why these men and some of their wives, who lived in that section, were drawing unemployment insurance, when they, and many hundreds of other men and women from all parts of the country, had come into Oregon without experience and had gotten work with ease.

My son turned to his wise old father and asked—"Why is that daddy?"

J. G. McDaniel, M.D.

blood pressure approaches normal
more readily, more safely.... simply
with
Salutensin[®]
(hydroflumethiazide, reserpine, protoveratrine A—antihypertensive formulation)

Early, efficient reduction of blood pressure. Only Salutensin combines the advantages of protoveratrine A ("the most physiologic, hemodynamic reversal of hypertension"¹) with the basic benefits of thiazide-rauwolfia therapy. The potentiating/additive effects of these agents²⁻⁸ provide increased antihypertensive control at dosage levels which reduce the incidence and severity of unwanted effects.

Salutensin combines Saluron[®] (hydroflumethiazide), a more effective 'dry weight' diuretic which produces up to 60% greater excretion of sodium than does chlorothiazide⁹; reserpine, to block excessive pressor responses and relieve anxiety; and protoveratrine A, which relieves arteriolar constriction and reduces peripheral resistance through its action on the blood pressure reflex receptors in the carotid sinus.

Added advantages for long-term or difficult patients. Salutensin will reduce blood pressure (both systolic and diastolic) to normal or near-normal levels, and maintain it there, in the great majority of cases. Patients on thiazide-rauwolfia therapy often experience further improvement when transferred to Salutensin. Further, therapy with Salutensin is both economical and convenient.

Each Salutensin tablet contains: 50 mg. Saluron[®] (hydroflumethiazide), 0.125 mg. reserpine, and 0.2 mg. protoveratrine A. See Official Package Circular for complete information on dosage, side effects and precautions.

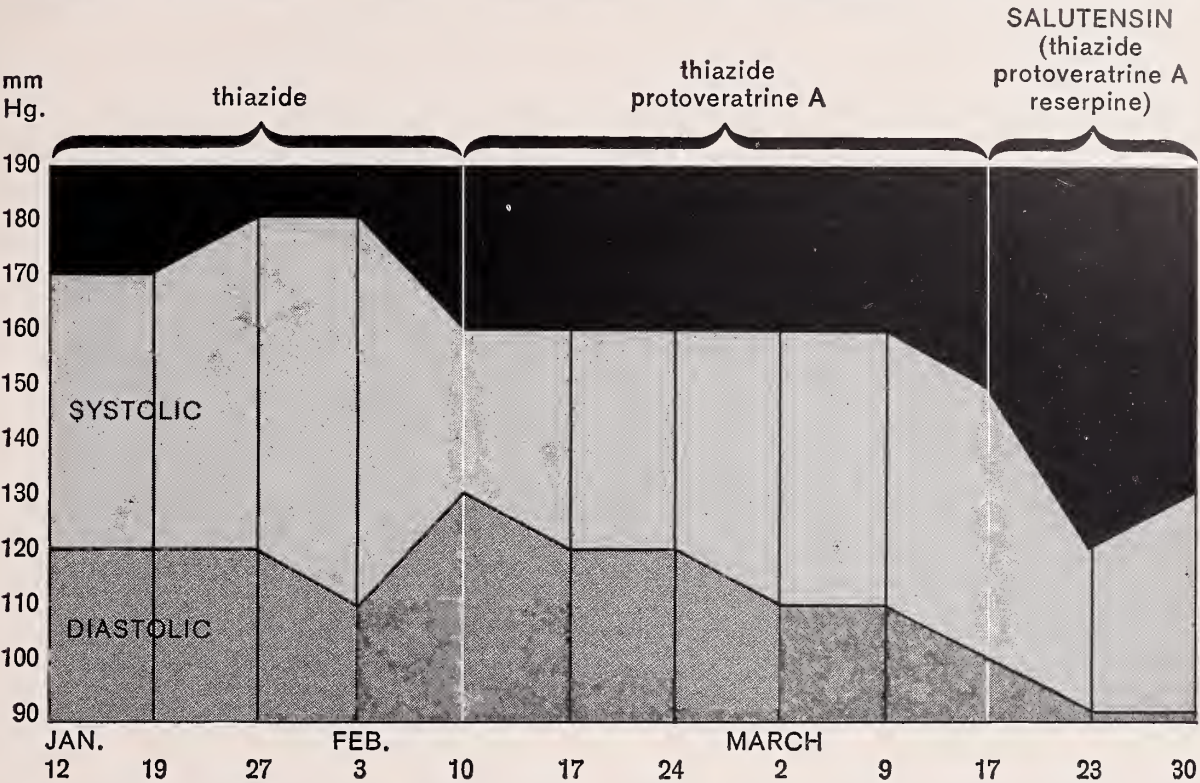
Supplied: Bottles of 60 scored tablets.

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all the antihypertensive benefits of thiazide-rauwolfia therapy plus the specific, physiologic vasodilation of protoveratrine A

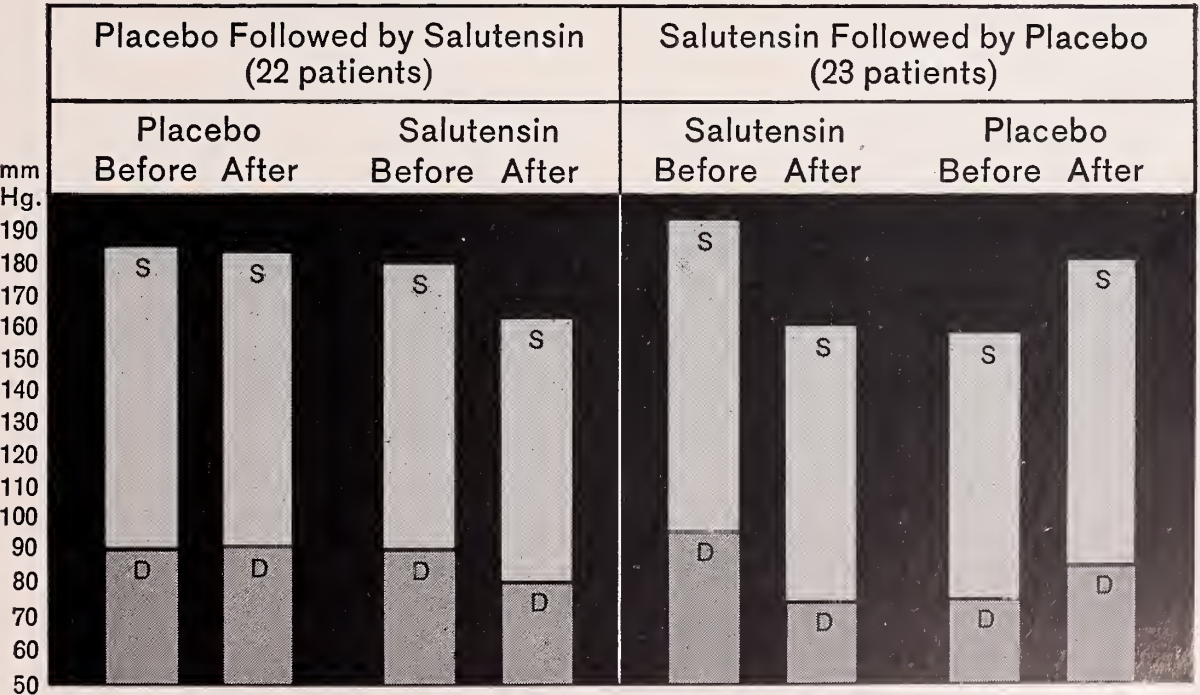
11 WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS BY SERIAL ADDITION OF THE INGREDIENTS IN SALUTENSIN IN A TEST CASE

(Adapted from Spiotta, E. J.: Report to Department of Clinical Investigation, Bristol Laboratories)



3½ WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS USING SALUTENSIN FROM THE START OF THERAPY IN A "DOUBLE BLIND" CROSSOVER STUDY

Mean Blood Pressures—Systolic (S) and Diastolic (D)



In this "double blind" crossover study of 45 patients, the mean systolic and diastolic blood pressures were essentially unchanged or rose during placebo administration, and decreased markedly during the 25 days of Salutensin therapy. (Smith, C. W.: Report to Department of Clinical Investigation, Bristol Laboratories.)



1962-63 CALENDAR OF MEETINGS

State

October 25-27—14th Annual Session of the Georgia Academy of General Practice, Atlanta Americana Motor Hotel, Atlanta.

May 5-8—Annual Session, Medical Association of Georgia, Jekyll Island.

Regional

September 6-8—American Association of Obstetricians and Gynecologists, The Homestead, Hot Springs, Virginia.

September 14-15—American College of Obstetricians and Gynecologists, District VII, Little Rock, Arkansas.

September 18-20—Kentucky State Medical Association, Brown Hotel, Louisville, Kentucky.

September 21-22—American College of Obstetricians and Gynecologists, District VII, Little Rock, Arkansas.

September 24-25—Tennessee Valley Medical Assembly, Chattanooga, Tennessee.

October 4-6—American College of Obstetricians and Gynecologists, District IV, Barringer Hotel, Charlotte, North Carolina.

October 14-17—Medical Society of Virginia, Sheraton-Park Hotel, Washington, D. C.

November 12-14—Southern Medical Association, Hotel Fontainebleau, Miami Beach, Florida.

November 12-15—Southern Medical Association, Hotel Fontainebleau, Miami Beach, Florida.

November 15-17—Southeastern States Cancer Seminar, George Washington Hotel, West Palm Beach, Florida.

National

July 23-27—Postgraduate course in Cardiopulmonary Problems in Children, Edgewater Beach Hotel, Chicago, Illinois.

August 26-27—American Academy of Physical Medicine and Rehabilitation, Hotel Commodore, New York City.

August 28-31—American Congress of Physical Medicine and Rehabilitation, Hotel Commodore, New York City.

August 30 - September 8—American Society of Clinical Pathologists, Palmer House, Chicago, Illinois.

September 1-4—College of American Pathologists, Palmer House, Chicago, Illinois.

September 17-November 9—Occupational Medicine, postgraduate course, New York University, New York City.

September 17-21—American College of Chest Physicians, postgraduate course, Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, Warwick Hotel, Philadelphia, Pa.

October 2-5—American Roentgen Ray Society, Shoreham Hotel, Washington, D. C.

October 4-6—American Medical Association First National Congress on Mental Illness and Health, Palmer House, Chicago, Illinois.

October 15-19—American College of Surgeons, Clinical Congress, Atlantic City, New Jersey.

October 17-18—American College of Preventive Medicine, Inc., Hotel Fontainebleau, Miami Beach, Florida.

October 20-26—Annual Otolaryngologic Assembly, postgraduate course, University of Illinois College of Medicine, Chicago, Illinois.

October 21-26—American Society of Anesthesiologists, Inc., Statler Hilton Hotel, New York City.

October 22-23—American Cancer Society, Biltmore Hotel, New York City.

October 22-26—American College of Chest Physicians, postgraduate course, Clinical Cardiopulmonary Physiology, Knickerbocker Hotel, Chicago, Illinois.

October 26-30—American Heart Association, Inc., Sheraton-Cleveland Hotel, Cleveland, Ohio.

October 27 - November 1—American Academy of Pediatrics, Palmer House, Chicago, Illinois.

October 28-31—American College of Gastroenterology, The Morrison, Chicago, Illinois.

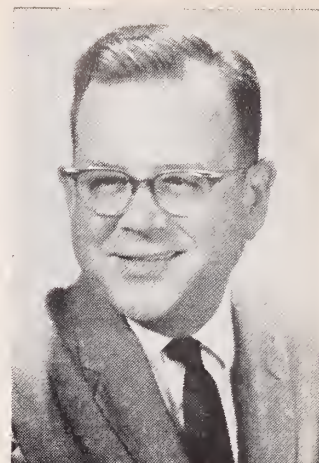
October 29-31—American Association for the Surgery of Trauma, The Homestead, Hot Springs, Virginia.

November 12-16—Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, Barbizon-Plaza Hotel, New York City.

November 25-28—American Medical Association, Clinical Meeting, Los Angeles, California.

"YOUR MONEY'S WORTH"

THOMAS W. GOODWIN, M.D.



RECENTLY A FRIEND of mine asked me what the yearly dues of the Medical Association of Georgia were. When I told him the dues were \$40 per year, he became rather disturbed. He then asked me the following two questions:

- (1) What does the Medical Association of Georgia do with all that money?
- (2) Did I honestly believe that the doctors who belong to the Medical Association of Georgia were getting their money's worth?

In order to answer these two questions, I am writing this letter, not only for the benefit of my friend, but also for the benefit of other members of the Association who might like to ask the same questions.

The Medical Association of Georgia was founded well over 100 years ago, and in its first Constitution and By-laws the purpose of the organization was defined. It has never been changed. It is as follows:

"The objects of this Association shall be the advancement of medical knowledge—the elevation of professional character—the extension of the bounds of medical science and the promotion of all measures adapted to relieve suffering humanity and to protect the lives and improve the health of the community."

In order to fulfill the high purposes for which this organization was founded, the Medical Association of Georgia does many things with your dues money. Among which are the following: Your organization engages in postgraduate medical education through its Annual Session, through its *Journal*, and through its seminars and short courses which it sponsors

from time to time. Your organization speaks with a state-wide voice in representing doctors of this state in legislative activities and liaison with other state agencies and departments, in public relations, and in the work of its boards and committees. Your organization sponsors numerous insurance programs for the members of the Association. Included in these are Group Life Insurance Policies, Health and Accident Insurance, and Catastrophic Hospital Coverages. The Association also makes available to you adequate professional liability insurance on a reasonable basis. Your Association also operates a Physician Placement Bureau, a Speakers Bureau, and gives free secretarial assistance to all specialty societies in the state. The Association acts as an informational and fact finding clearing house for the doctors, County Medical Societies, and District Medical Societies within the state. It administers the Armed Forces Medicare Program and the Kerr-Mills Program for the Aged on a state-wide basis. It makes available adequate legal council in matters relating to their practice. It offers inter-professional liaison with other state-wide organizations and it operates an accreditation program for smaller hospitals in our state. To accomplish all these purposes, the Association owns a Headquarters Office Building in Atlanta and operates its office with a staff of qualified personnel.

In view of all these activities which your state Medical Association performs, I feel that the answer to my friend's second question as to whether the members of the association are getting their money's worth is an emphatic, "YES."

Thomas W. Goodwin
President, Medical Association of Georgia



ROTATING DUTY IN EMERGENCY ROOM

John L. Moore, Jr., *Atlanta*

A RECENT INQUIRY raises the issue of the practice in hospitals of rotating duty in the hospital emergency room among all of the physicians in the community, even though some of such physicians may be specializing and not have recent general experience.

Naturally, the question arises as to the standard of care required of such a specialist. For example, would the otolaryngologist on duty be held to the standard of care of an orthopedist in setting bones or of a cardiologist in case of cardiac arrest?

A 1957 Ohio case involved a patient who was injured, when fighting with another person, by being pushed through a plate glass door. He suffered lacerations of his right shoulder and upper arm and a small puncture wound on his right chest. He was taken to the emergency room of the hospital and given treatment by an interne in the employ of the hospital. The claim for damages was based on the proposition that the interne closed the plaintiff's wounds without probing them, leaving glass in the shoulder. In affirming a judgment for the hospital, the Court of Appeals of Ohio said:

"However, this standard of skill is not absolute in all cases. It would be unreasonable to exact from an intern, doing emergency work in a hospital, that high degree of skill which is impliedly possessed by a physician and surgeon in the general practice of his profession, with an extensive and constant practice in hospitals in the community."

The Court went on to find that the interne did bring to his work the degree of care and skill required of an experienced physician and surgeon. Consequently, the language of the Court above quoted does not have quite the force it would have otherwise.

In a 1960 California case, a general practitioner was on emergency duty at the hospital. An automobile accident occurred and the patient sustained head

injuries. The general practitioner took care of the bleeding but took no x-ray, thinking it better for the neurosurgeon to make the x-ray. The general practitioner sent the patient in an ambulance to another hospital, where the neurosurgeon practiced, with no special instructions given to the ambulance driver. The patient was dead on arrival at the other hospital. The general practitioner was held not liable because of a failure to prove that his actions were the proximate cause of the death rather than the automobile accident. However, the Court expressed great criticism of the general practitioner, saying that he should have taken an x-ray and given special instructions to the ambulance driver.

The Law Department of The American Medical Association, in January, 1961, commented on this issue. The Law Department concluded that the duty of the receiving physician is to treat for shock, stem the rapid loss of blood, make the injured person as comfortable as possible, keep him under constant surveillance, and immediately summon either the family physician or the type of specialist indicated by the nature of the injuries. The Law Department indicated that this might be considered a high degree of "first aid." The Law Department does not base its opinion on any particular case but on general principles. It will be observed that the California general practitioner mentioned above probably did not live up to the standards suggested by the Law Department of the AMA.

In Georgia, the courts have consistently refused to require of specialists a higher degree of care and skill than that generally brought to the profession by a physician and surgeon. It is possible that the Georgia courts would reverse this standard and say that a specialist who has not practiced general medicine in many years should be held to the same general standard of care and skill as any other general practitioner in the community. Such a holding would not be consistent with the general principles relied on by the Law Department of the American Medical Association.

Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

No firm answer can be given to the question raised in this article. However, it would appear to the writer that the desirability of the rotating system would have bearing on a holding by a court with the result that a specialist in the emergency would only be required to bring to the emergency room that degree of care and skill he could be expected to have.

Factors which should be taken into consideration would be the amount of general experience and training of the physician and the number of years since he has practiced outside his specialty. Naturally, a court would very likely hold a specialist to a normal degree of care and skill when presented a problem within his own specialty.

THE MONTH IN WASHINGTON

The American Medical Association challenged the Kennedy Administration on the accuracy and legality of its propaganda campaign for the King-Anderson bill.

Dr. F. J. L. Blasingame, Executive Vice President of the AMA, wired Attorney General Robert Kennedy about a booklet issued by the Department of Health, Education and Welfare. Dr. Blasingame said:

"This booklet lobbies for the enactment of the King-Anderson bill. This bill would raise social security taxes to provide limited health services to aged beneficiaries, regardless of whether they need financial help.

"The Department of Health, Education and Welfare has used tax funds, collected from everyone, to propagandize for a bill which many people and many groups have vigorously opposed. Under law, the publishing of this kind of a booklet without Congressional authority is a criminal act, punishable by fine or imprisonment, or both, and removal from office."

AMA President, Dr. Leonard W. Larson, wrote President Kennedy correcting a misstatement the Chief Executive made at a news conference.

The President told his news conference that "the AMA was one of the chief opponents of the Social Security system in the 30's."

Dr. Larson pointed out to Mr. Kennedy that the American Medical Association had never opposed the Social Security system, either before or after its adoption.

"The Association," Dr. Larson's letter said, "testified before Congress on only one section of the Social Security legislation, the section concerning extension of public health services. It should be noted that the AMA testified in support of this section."

Dr. Blasingame also called on the Justice Department to stop Cabinet members using taxpayers' money for lobbying purposes and to launch an investigation of "improper" lobbying activities of employees of the Department of HEW.

Dr. Blasingame, in a letter to Attorney General Robert Kennedy, listed more than a dozen incidents which he said violated federal statutes prohibiting lobbying by federal employees and officials.

"Government employees," Dr. Blasingame said, "are being sent out as speakers, at public meetings, to urge enactment of the Administration's bill. This, in our opinion, is a clear violation of Title 18, Section 1913 of the U.S. Code on crimes and criminal procedure which prohibits among other things the use of 'personal services' for lobbying purposes."

Dr. Blasingame said that Secretary of Commerce, Luther Hodges; Secretary of Labor, Arthur Goldberg; and Interior Secretary, Stewart Udall; were appearing at

rallies concurrent with President Kennedy's appearance in Madison Square Garden in the Administration's campaign for the King-Anderson bill.

"We strongly protest the use of tax money by these Cabinet members to lobby for a bill which is clearly not within the scope of their respective departments," Dr. Blasingame said. "I call on you to issue an injunction against this type of activity by these Cabinet members."

The AMA Executive Vice President also noted that between six and ten government employees "have been lobbying in the White House offices for several months," for the King-Anderson bill. He said the group occupying a four-room suite "has been writing television and radioscripts, drafting advertisements, and helping with publicity releases for various organizations which are backing the King-Anderson bill."

Dr. Larson also urged that "the American people demand an honest accounting from the Department of Health, Education and Welfare on how much of their tax money the department is spending on lobbying for the King-Anderson bill."

"The people have a right to know how much of their tax money this federal agency is spending in lobbying for this piece of legislation," Dr. Larson said in a speech before the Academy of Medicine of Cincinnati.

Dr. Larson said also that the National Council of Senior Citizens should be required to register as a lobbyist.

"This organization was founded by former Congressman, Aime Forand, for the express purpose of lobbying for passage of the King-Anderson bill," Dr. Larson said.

In a statement, Dr. Larson cited contradictory statements by two prominent advocates of President Kennedy's health-care-for-the-aged bill—Ribicoff and Rep. Cecil R. King (D., Calif.).

"Mr. Ribicoff and Mr. King may be on the same team, but they are in basic disagreement as to the extent of services social security should provide and how much of an increase in taxes the public will tolerate to finance these services," Dr. Larson said.

Dr. Larson said: "This is what is happening; Secretary Ribicoff, in an effort to make the King-Anderson bill palatable to those fearing greater Federal taxes, is saying that the health care program will not be expanded because social security taxes have just about hit ten per cent—his estimate of the saturation point.

"Meanwhile, Mr. King, in order to gain the support of those who believe in the 'Federal government playing the role of Santa Claus' is promising increased social security benefits in the future."



"THE ANALYTICALLY — ORIENTED PSYCHOTHERAPEUTIC PROCESS"

L. A. Cibelli, M.D., *Atlanta*

IN ORDER for therapy to be meaningful and successful, it is important to identify the psychotherapeutic process in all of its aspects. This, of course, would include the process going on in the therapist himself during the course of treatment.

How do we go about identifying the process taking place? We observe events which are a simple and direct expression of that process, or we observe events which are complicated and condensed. The events, generally speaking, are thoughts, feelings, and actions. These are, in a particular patient, in relationship to himself and to others, which would include the therapist. They are reported as the patient sees them, in terms of current meanings to him. To be observed, therefore, are the changing meanings to the patient as he progresses. The events the therapist observes are more or less direct expressions of the nuclear psychic and physical processes going on in the course of treatment.

When we observe, we stand at the periphery. If we observe in detail and accurately, that is objectively, without bias and rigid preconceived notions, we will in time see patterns, configurations, and themes repeat themselves. Then, as more time elapses, we will become attuned to the patient's particular tempo and rhythm. Of course, and of necessity, we will be making these observations with our own individual background and experience, and the particular theory of human motivation with which we operate.

When does the psychotherapeutic process begin? It begins with the very first contact with the prospective patient, whether this be in person, via telephone, or in the form of a letter. Or, as someone has aptly put it, it begins "at the turn of the doorknob leading to the treatment or consultation room."

Initial Interview

This phase of the therapeutic process is sufficiently understood and I will not dwell upon it at length.

Suffice to say that it is of the utmost importance for the therapist to decide at the earliest possible moment: "Who" is seeking treatment, "Why," and "Why at this particular time"? The first of these may sound rather ridiculous. However, upon further investigation, it will soon be clear that it is *not* the person being interviewed. It may well be his spouse, his employer, the police authorities, a trial judge, or even a probation officer who initiates the request for treatment.

The Life History

Under this heading I will combine the life history before therapy and the life history during therapy, as a matter of convenience. As the patient tells his story he will unveil his total character structure with all of the influences, both good and bad, having to bear upon the development of this particular character structure. These influences, of course, have to do primarily, but not all together, with his childhood experiences with important people in his environment. He will also give a good idea as to whether the emotional climate within the home was good, bad, or indifferent. The emphasis here is not on the experiences themselves, but rather his reactions to them. During therapy, either in detail or in big sweeps, we will be able to observe the emergence of changing reactions, attitudes, and values, with regard to these experiences in the current situation.

A Segment of the Therapy

At the end of the first few sessions you will have gathered a tentative total impression of your patient and have arrived at a plan of conducting the therapy. What has transpired can be summed up from three vantage points. These are: (1) What was done, (2) What was accomplished in so far as movement is concerned, and (3) What is to be done and how to go about doing it. What was done includes what you did, your patient did, and what the environment

did. The second vantage point has to do with conduct of the therapy itself. Your therapeutic objectives vary from time to time with more or less emphasis on patching your patient together. It also has to do with building a relationship with him, analyzing his neurotic attempts at solving his problems, and identifying and utilizing his constructive resources. And,

finally, from the third vantage point you attempt to carry on an educative program which, in short, means preparing your patient for a more effective participation in the therapy itself and for his own self-analysis.

This, in effect, ultimately leads to the search for Self and in the direction of Self-realization!

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

CONGRESSMAN CARL VINSON WRITES ON THE KING-ANDERSON BILL

The following letter received from Congressman Carl Vinson reveals a penetrating insight into the fallacies of the King-Anderson bill and the philosophy on which it is based. Mr. Vinson's letter is reprinted in full here, in order that you may share the sound arguments which he propounds.

June 4, 1962

Milford B. Hatcher, M.D.
781 Spring Street
Macon, Georgia

Dear Dr. Hatcher:

Thank you for your recent letter in which you have stated your opposition to the King-Anderson bill, involving medical care for the aged.

Let me say at the outset that I have discussed this bill with the Chairman of the Ways and Means Committee, and many members of that Committee. I know that many amendments will be offered to the bill, and I am confident that if the bill is reported by that Committee, it will be considerably changed from the bill that was introduced. However, I doubt that it will be reported out of the Committee.

Nevertheless, I have given considerable study to the information that I have received from various physicians, as well as various insurance companies on this matter.

Frankly, I am concerned about the projected cost estimates should the King-Anderson bill be enacted into law. The Department of Health, Education and Welfare estimates an eventual cost of \$2½-billion a year, while insurance actuaries, who are probably far more knowledgeable in this field, estimate that the cost would rise to \$5.4 billion a year by 1983.

In addition, there are other features of the King-Anderson bill which bother me, such as the fact that the bill, as now written, excludes many persons who are now over the age of 65 and who can never qualify for Social Security or Railroad Retirement benefits. I also note that the King-Anderson bill does not cover the cost of physicians' care, private duty nursing, and drugs and medicines furnished outside the hospital, among other things.

In studying this matter, I have also learned that a total annual medical bill of \$177 was the average cost for a person of 65 and over in the 1957-58 period. If so, then the benefits available under the King-Anderson bill would only meet about one-fourth of this total average cost, with the patient being required to pay the

remainder. This does not appear to be much of a benefit to the individual, and yet the future costs of the program would be staggering.

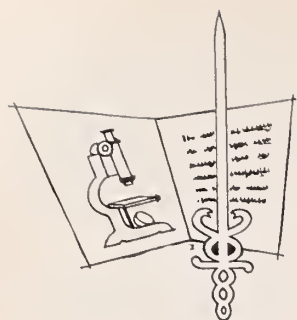
I am also impressed with the number of insurance programs that are now available on a voluntary basis. These private plans, or cooperative plans, provide considerably more coverage for the individual's personal benefit. In that regard, I was interested to learn that today more than 70 per cent of the total population is covered by private health insurance and 50 per cent of persons over the age of 65. Under the circumstances, it seems to me quite possible that a government-sponsored program could be devised similar to the government employees life insurance program which would provide for a partial federal contribution to private insurance companies, or to cooperative plans, either in the form of a tax credit or as an outright contribution for those who are unable to pay for the full coverage. This might be considerably cheaper, and at the same time, might provide far greater coverage. It would also have the added advantage of aiding those who *need assistance* and yet preserve the concept of free enterprise and eliminate the potential danger of socialized medicine.

I mention all of this to indicate that I have given the matter considerable thought and study.

I believe that some action must be taken to provide assistance for elderly persons who may be faced with ruinous costs in the event of serious illnesses. However, I am not wedded to any particular form of assistance, and I am concerned about the very substantial cost estimates that I have seen with regard to the costs of the King-Anderson bill, as it is now written. Most persons seem to agree that catastrophic illnesses must be guarded against, but we must certainly be sure that the solution adopted is (a) necessary, (b) sound, and (c) keeps the medical profession independent.

Please be assured that I will give this matter very careful consideration before I arrive at a final determination in this matter. I also want you to know that I appreciate having your views on this subject.

Carl Vinson
Member of Congress



"RESURVEY OF CANCER RESEARCH AND ACTIVITIES OF THE AMERICAN CANCER SOCIETY"

(PART II)

A. H. Letton, M.D., *Atlanta**

LAST MONTH we discussed Cancer research in virology, immunology, and chemotherapy. Let us continue our discussion by looking at research in the field of epidemiology.

Examples of research in epidemiology are found in such programs as the "Cancer Prevention Study" of the American Cancer Society. In this study, 70,000 trained volunteers make annual visits to 1,085,000 men and women over the ages of 30, checking on their family history, past history, physical complaints, environmental exposure, occupation, habits, diets, etc. All of these facts are then turned over to statisticians, in the hope that the I.B.M. Electronic Brain may be able to find some common factor among those individuals of this group who will develop cancer. Incidentally, there are 28,000 Georgians among this group, and some of them are probably patients of yours and mine.

Hammond and Horne are continuing their "Tobacco-Lung Cancer Study" in which they annually question a group of over 200,000 men (this group is composed of men over the age of 60). Their health and habits are tabulated, and then each year they go back to these same men and see how they are getting along. The cause of death of any of them who have died in the meantime is very carefully investigated. You will recall that the preliminary report released a few years ago showed that there was a great correlation between heart disease and tobacco smoking, and then a very definite, if somewhat less, correlation between tobacco smoking and lung cancer.

These are but a few of the many examples of how the \$111,000,000 is being used to find cancer's cause and cure. There are too many factors for us to mention here in this short period of time.

It was also the program committee's thought that I should bring you up to date on the plans for Public Education in the forthcoming year by the American Cancer Society because you will be hearing about this as your patients take part in these programs.

The Federated Woman's Club of Georgia has joined with the Georgia Division of the American Cancer Society in trying to familiarize all of its membership, as well as the other women of Georgia, with the Papanicolaou Smear technique of screening for cancer of the cervix. Every woman in Georgia over the age of twenty-five is urged to have Papanicolaou Smears done in order to find cancers earlier with a resulting reduction of mortality from carcinoma of the cervix. They are entering also into an educational program on cancer of the colon and rectum to get patients to submit to digital rectal examinations (where forty per cent of the carcinomas of the colon can be felt within reach of the finger), and to submit to sigmoidoscopy (seventy per cent of the carcinoma of the colon develops in the portion of colon visible by sigmoidoscopy). These examinations will find these tumors at an earlier date and bring about a greater cure rate among the people of our state. We hope to obtain a cure rate of some 75 per cent which is possible with cancer of the colon, instead of about 25 per cent which we are doing.

Within the last two months here in Atlanta, every volunteer who went out to represent the Cancer Society in its annual crusade was urged to take a

*Chairman—Region III, National American Cancer Society, Delegate
Member—Georgia Division.

special course for the layman in cancer for two reasons. First of all, this will inform the some six thousand laymen volunteers in our city and will help them take care of themselves. Secondly, it is hoped that this information will be given, in turn, to some of the volunteers' neighbors upon whom they call, and thus an even greater dissemination of knowledge about cancer, with a resulting increase in cancer cures, will be forthcoming.

Atlanta has been used in this pilot study, and deci-

sions are being made now as to the desirability of having other cities in America follow the leadership of Atlanta in this important work of educating the public about cancer. Certainly, there are many curable lesions which are going unseen by our profession until they become incurable. This education program is designed to save these lives—not to scare people, but to make them concerned, for only the concerned person takes action in important matters.

Approved by Professional Education Committee, Georgia Division, ACS.

AMEF CONTRIBUTORS

<i>Name</i>	<i>Address</i>	<i>Name</i>	<i>Address</i>
Austin, Jack	Griffin	Lee, Howard	Decatur
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Bibb County Woman's Auxiliary	Macon	Mann, Frank, Jr.	McRae
Barton, Wm.	Macon	Moore, Haywood	Brunswick
Birdson, Wm.	Macon	McDonald, James	Athens
Colquitt, Hugh	Marietta	Miller, Robt.	Jesup
Conn, Lee	Columbus	Muscogee County Woman's Auxiliary	Columbus
Cacchioli, Louis	Hartwell	Okel, B.	Decatur
Clark, S., Jr.	Waycross	Rayle, Albert, Jr.	Atlanta
Cousins, Wm.	Tucker	Richardson, A., Jr.	Atlanta
Chatham County Woman's Auxiliary	Savannah	Raybourne, Jack	Macon
Cook, Mrs. W.	Columbus	Richmond County Medical Society	Augusta
Coffee County Woman's Auxiliary	Douglass	Rosen, Saml	Savannah
Dugan, Asa	Washington	Reeve, Thos., Jr.	Carrollton
Davis, Floyd	Waycross	Stroup, David	Atlanta
Duncan, G.	Decatur	Slade, Ira, Jr.	Griffin
DeKalb County Woman's Auxiliary	Decatur	Stewart, J.	Macon
Elkins, James	Columbus	Smith, Leo	Waycross
Foster, Blake	Pelham	Smith, Richard	Cochran
Fowler, Herbert	Marietta	Shinall, Robt., Jr.	Atlanta
Fokes, Robt., Jr.	Moultrie	Spalding County Woman's Auxiliary	Griffin
Fulton County Woman's Auxiliary	Atlanta	Threatte, Bruce	Columbus
Goldberg, Ira	Augusta	Thompson, Wm.	Marietta
Goodman, Leon	Macon	Troup County Medical Society	La Grange
Hubbard, Davis	Atlanta	Tryon, Wm.	Blue Ridge
Hutto, George	Columbus	Upshaw, Chas., Jr.	Atlanta
Hagood, Murl	Marietta	Upson County Medical Society	Thomaston
Habersham County Woman's Auxiliary	Clarksville	Zakitis, Vilis	Milledgeville
Kelley, J.	Griffin		



THE ROLE OF SYMPATHECTOMY IN PERIPHERAL VASCULAR DISEASE

William C. McGarity, M.D., *Atlanta*

SYMPATHECTOMY IS NOW well established as a valuable surgical procedure in the treatment of peripheral vascular diseases. Its chief value is that it effectively relieves vasospasm and promotes the development of collateral arterial circulation.

Sympathectomy may be expected to eliminate sweating and the neurocirculatory component of arterial disease, as well as to accomplish maximum vasodilatation of the arterioles in the skin. Since this procedure does abolish sweating and increases skin circulation, it is valuable in lessening the danger of infection and superficial necrosis in those patients having certain types of peripheral vascular disease accompanied by some degree of vasomotor or sympathetic activity.

Most physiological evidence supports the view that the sympathetic innervation of muscle blood vessels is negligible. However, clinically, muscle circulation derives some benefit from sympathectomy. This is more striking in early cases of claudication. Improvement in the collateral circulation to the skin seems to benefit the muscle with an increased flow of blood through the communicating vessels between the superficial and deep systems. It also should be remembered that sympathectomy definitely relieves pain sometimes independent of a circulatory effect.

There is no foolproof method of predicting which patients will or will not respond to sympathectomy. It is important to evaluate the evidence of an active vasoconstrictor mechanism, the adequacy of the collateral circulation, and the degree of impaired arterial blood flow. There are various ways of interpreting the vasoconstrictor mechanism. The most accurate is a paravertebral sympathetic block. An increase in temperature of the involved limb and relief of pain after block, indicates that a good result will be obtained from a sympathectomy. Only a positive response is significant. It is also well recognized that improvement in circulation and pain, after removal of the sympathetic chain, may take place over a pe-

riod of weeks or months. This is particularly true of disorders such as arteriosclerotic disease. For this and other reasons sympathetic blocks are not indicated in all patients being considered for a sympathectomy.

The adequacy of the collateral circulation can be determined by noting the degree of blanching on elevation, the amount of cutaneous congestion on dependency, and the rate of venous filling. If the limb does not significantly blanch on elevation in less than 120 seconds, if flushing time is 20 seconds or less on dependency, and venous filling occurs in 30 seconds or less on dependency, the collateral circulation is good.

The degree of impaired blood flow in the main arterial tree is determined by observation of pulsations in the major vessels and by arteriography.

The primary indication for sympathectomy is in patients with peripheral vascular disease caused by vasospasm or with a large vasospastic element. Exceptionally good results can be anticipated when the symptoms and signs are caused almost wholly on the basis of vasospasm.

Sympathectomy may be used as a direct attack on many vasospastic disorders, such as Raynaud's disease and allied states which exhibit the Raynaud's phenomenon; post-traumatic arteriospasm; hyperhidrosis, especially that following frostbite; and certain instances of causalgia. Sympathectomies are also used in conjunction with direct vascular surgery in the treatment of acute arterial interruption, such as trauma or embolism, when associated arterial spasm may seriously jeopardize the survival of an extremity.

Lumbar sympathectomy has not been found useful in the treatment of chronic peripheral venous disorders. However, it may occasionally be of value in the treatment of vasospasm associated with acute thrombophlebitis. Phlegmasia caerulea dolens (acute femoro-iliac thrombophlebitis) may be associated with, if not actually a reflex cause of, arterial spasm

serious enough in some cases to induce gangrene of the limb. If the patient's condition permits, and the arterial spasm cannot be adequately controlled by lumbar sympathetic blocks, sympathectomy should be considered.

Operation to re-establish the continuity of the vessel by removing or by-passing the occluded area is the treatment of choice when one is dealing with arteriosclerotic peripheral vascular disease of a localized nature. Occasionally it may be desirable to perform concomitant sympathectomy when carrying out direct arterial surgery to re-establish the blood flow to the extremity. Dilation of the peripheral vessels may promote better runoff and keep the graft patent. If the latter becomes occluded, the extremity may have extra protection.

In patients with arteriosclerotic peripheral vascular disease of a generalized nature, involving smaller vessels, sympathectomy should be considered when reasons of judgment indicate that direct vascular surgery is not feasible. Direct surgery is usually doomed when smaller vessels are involved, and the runoff is not adequate. Sympathectomy will give some relief of symptoms. It must be remembered that with arteriosclerotic disease, sympathectomy is purely a palliative procedure. However, in this group of patients it is the only other therapy that offers the patient any hope of improvement from the symptoms of claudication and arterial insufficiency. In many patients, this operation increases the blood supply to the distal structures by relieving vasospasm and per-

mitting expansion of small unaffected collateral channels. Improvement can be looked for in a larger percentage of patients than one would ordinarily think possible. Although improvement may not be immediate, downhill progression of the disease can be halted and improvement can be noticed over a period of six or more months. Certain protection also will be provided against the most serious complication of obliterative vascular disease, the loss of an extremity. Claudication is seldom completely relieved, but even minor degrees of improvement are helpful.

Sympathectomy may sometimes, but rarely, be useful in lowering the level of an amputation.

In summary, sympathectomy plays an important role in the treatment of patients with peripheral vascular disease when symptoms and signs are on the basis of vasospasm. Sympathectomy can be valuable in many patients with occlusive disease where direct arterial surgery is not warranted. If used in early or moderately severe stages, one can expect warming of the skin, increase in life expectancy of limbs, and occasional improvement of claudication. In the elderly patient, with ischemic necrosis and diffuse vascular disease, the benefit from sympathectomy may not justify the risk. The procedure may be useless when collateral circulation is minimal or when the terminal vascular bed is closed. Sympathectomy is unnecessary when the disease has sympathectomized the patient. This occurs in some types of diabetic neuropathy.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

GEORGIA HEART ASSOCIATION ADOPTS 1962-63 BUDGET

The Board of Directors of the Georgia Heart Association has adopted a budget of \$527,320.00 for the fiscal year beginning July 1, 1962, including a record \$192,175.00 for research.

This action was taken at a two-day meeting of the Board of Directors of the Georgia Heart Association held at the Americana Motor Hotel in Atlanta on Saturday and Sunday, May 26th and 27th, 1962.

According to Georgia Heart Association Board Chairman, Carter L. Redd, the research allocation includes sixteen research grants in Georgia and partial support of three American Heart Association grants to Georgia institutions, totaling \$116,950.00, plus \$75,225.00 to the national research program of American Heart.

The budget also provides for continuation of professional and public education in the field of cardiovascu-

lar disease, support for the Georgia Heart Clinic System for indigent patients, further development of community heart programs, fund raising, and administration of the association.

The Board approved a goal of \$550,000 for the 1963 Heart Fund drive and budgeted \$46,500, or 8.4% of the goal, for fund raising costs.

"The increased allotment to research is possible," Mr. Redd pointed out, "because of increased support from the people of Georgia in the 1962 Heart Fund drive."

Although final figures were not available until June 30, the budget was adopted on the basis of anticipated returns of better than \$510,000 or an increase of approximately \$40,000 in Heart Fund returns over the previous year.

DOCTORS HOLD 4TH ANNUAL CONGRESSIONAL LUNCHEON

"As doctors and as constituents you have a right to demand something of your Representatives in the Congress." This lucid and penetrating statement was made by Congressman E. L. (Tic) Forrester of Georgia's 3rd Congressional District to a gathering of Georgia physicians at the 4th Annual Congressional Luncheon in Washington on June 5, 1962.

Four years ago somebody at the Medical Association of Georgia conceived the idea of holding a Congressional luncheon in Washington, D. C., for the purpose of honoring the members of the Georgia delegation in the Congress. Since that time this affair has become a permanent fixture on the yearly projects calendar of the MAG Legislative Board. This once-a-year luncheon for Georgia Congressmen and Senators is felt by most who have participated to be MAG's best single effort in the political relations field.

The 1962 Annual Congressional Luncheon was held on June 5th, and as in previous years, was a big success. All members of Georgia's 12-man delegation were invited to attend and all but two were able to be present. Of the two who could not join us on this occasion, Representative J. L. Pilcher was out of the city at home in his Southwest Georgia Congressional District, and Congressman Carl Vinson was in Macon to receive an honorary degree from Mercer University, his Alma Mater.

The luncheon was arranged through the good offices of Congressman James C. Davis of Georgia's Fifth District and was held in the private dining room of the Speaker of the House of Representatives.

Prior to descending on Capitol Hill to contact our Members of Congress, our traveling delegation called on the Washington office of the American Medical Association for a briefing on the latest developments surrounding the Social Security health care legislation and

other matters of general interest. Here a staff of experts in the field of Congressional affairs gave us a crystal clear picture of the legislative mosaic of which H.R. 4222 (King Bill) is but a part. Following this, doctors individually and in small groups called on their Members of Congress at their respective offices. At 12:30 everyone assembled at the Speakers Dining Room for lunch and an informal "round robin" session.

Each Congressman was introduced by his physician-constituent and given an opportunity to say a few words to our group.

Ten Georgia doctors, one from each Congressional District, made this overnight trip to Washington and each has reported that as a result of these annual luncheons a greatly improved rapport exists between members of the medical profession and Members of Congress.

As a long range project by which to improve relations between the doctor and his lawmaker, the annual luncheon with its personal contact feature has no equal. While this affair was conceived as a means of saying to our Representatives, thank you for a job well done, there is also another side to this coin. Plainly spoken it is this: as members of a profession beset from all sides by those who would interfere with the practice of medicine, doctors have a message to tell their legislators. A message not filled with the partisan wishes of a special interest group, but one of dramatic accomplishments in the past and one of great promise for the future. We can report that our Representatives listened attentively and with appreciation to the doctor's side of the story.

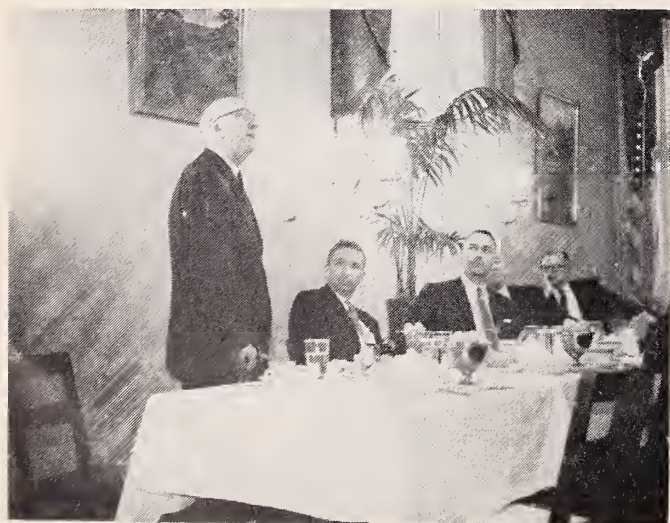
COURSE IN POSTGRADUATE GASTROENTEROLOGY

The Annual Course in Postgraduate Gastroenterology of the American College of Gastroenterology will be given at the Morrison Hotel in Chicago, Ill., November 1, 2, 3, 1962.

The College is most happy to announce that after a three-year absence the Moderators for the Course will again be Dr. Owen H. Wangenstein, Chairman and Head of the Department of Surgery of the University of Minnesota School of Medicine, and Dr. I. Snapper, Director of Medical Education, Beth-El Hospital, Brooklyn, N. Y.

The faculty for the Course will be drawn from the Medical Schools in and around Chicago. The subject matter to be covered, from the medical as well as the surgical viewpoint, will be essentially, the diagnosis and treatment of gastrointestinal diseases and comprehensive discussions of diseases of the mouth, esophagus, stomach, pancreas, spleen, liver and gallbladder, colon and rectum. A Clinical session will be held at the Cook County Hospital in addition to the several individual papers to be presented.

For further information and enrollment write to the American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.



Senator Richard B. Russell makes a point at the recent gathering of Georgia physicians in Washington for the 4th Annual Congressional Luncheon. Seated from left to right: Richard Nelson, AMA Field Representative, Chicago; Dr. W. Frank McKemie, Albany; Congressman Phil M. Landrum, Georgia, 9th District; and Dr. C. J. Roper, Jasper.

GUIDE FOR COMPLETING MEDICARE CLAIM FORMS

AS A RESULT of the fact that almost one in every five claims received in the Medicare Office must be returned to the physician for some item to be completed or corrected, the following information is submitted in order that claims may be more easily processed. It is believed that use of this information will facilitate processing the claims and result in fewer delays and returned claims.

1. (a) Spouses and children residing apart from sponsor will be allowed selection of either uniformed services medical facilities or civilian sources for care authorized under the Program.
(b) Spouses and children *residing with sponsor* and desiring care at government expense will be required to utilize a uniformed service medical facility in the area in which residing if medical facilities are available as determined by the Commander of the medical facility. When uniformed services facilities are not available, a Medicare Permit or a NON-AVAILABILITY STATEMENT (Form DD 1251) will be furnished such dependents by the appropriate Commander, authorizing them to seek authorized medical care from civilian sources. This statement must be attached to the claim form. (Item 3)
2. (a) Medical Authorization Card Number (Form DD 1173)—(Item 7). This number will always have a two-letter alphabet prefix and this must be shown.
(b) Expiration Date. The card is valid only from the date of issue or retroactive beginning date through the expiration date shown thereon. A specific date of expiration **MUST** be shown. To say that the card is valid for an "indefinite" period is **NOT** correct. It should be noted that lack of the correct information in this item has been the principle cause of returning claim forms so far this year.
(c) The services must be rendered between the beginning and expiration dates on the Medical Authorization Card; that is, while the card is valid.
3. Duty Station. The official duty station of the sponsor, including base or fort and state or nation, must be shown. This has been another major cause of returning claims.
4. (a) Include each period during which service was rendered (Item 21).
(b) In maternity cases, give date of first antepartum visit.
(c) In cases where the physician is rendering postpartum care, the normal Medicare fee covers the entire six weeks period after delivery and the last date in item 21 should reflect a date six weeks after delivery.
5. Payment for psychiatric care can be made only when the physician certifies, as per item 20, that the situation was a bona fide acute emergency.
6. Complete diagnosis according to the standard nomenclature (Item 22).
7. (a) List services rendered and type of procedure on each claim (Item 25).
(b) In maternity cases, give date of delivery and in anesthesia cases, the duration of anesthesia.
(c) List names of other physicians involved in the case.
8. (a) State if any fee has been paid by the patient. (Item 27).
(b) Outpatient care is authorized for payment only in connection with maternity or injury care or for necessary tests and procedures performed or authorized by the attending physician for some bodily injury or surgical procedure for which the patient is hospitalized.
(c) The physician is reminded that in cases of out-patient care for treatment of injuries, the patient is responsible for the first \$15.00 of the physician's bill. This should be reflected in item 27.
9. The physician whose name and address appears in Item 14 must sign the claim form. A rubber stamp is not acceptable. (Item 29).
10. The physician may keep the third copy of every claim for his files.
11. Full instructions can be found on the reverse side of every claim form. For further information write: Medicare, Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta 9, Georgia. Telephone TRinity 5-6303.

NOTE:

Please clip and give to office personnel filing medicare claim forms.

THE CASE FOR VOLUNTARY HEALTH INSURANCE

Almost everyone knows that medical care for the aged has become a redhot political issue in recent years. Some of our people have asked whether the Company has taken any stand on the latest proposal to increase the scope of Social Security to include benefits for paying hospital and nursing home bills for people over age 65.

The policy of the Company is to serve the needs of all the citizens in the territory in which we operate. Certainly we do not wish to deny anyone, least of all our senior citizens, the care needed for the preservation of life and health. But we do not feel it is the responsibility of the taxpayers to provide for those who are able to provide for themselves.

This issue goes right to the heart of the difference between two basic philosophies of government—those who want the federal government to assume still another responsibility which now rests with us as individuals, and those who believe that a government should do for its people only those things which the people cannot do for themselves.

We believe that further government action in this area is unnecessary and undesirable. We believe it is unnecessary because, as a class, older persons are very much like people of all ages. Some have ample means, some are moderately situated and others are poor. The health care needs of the aged are rapidly being provided for through the present voluntary system, and through those government programs which have already been enacted.

This issue is charged with emotion—so much so that those who favor the Social Security approach have suggested that those opposing it are against good medical care for the elderly. Those who oppose the Social Security approach believe that good medical care for the elderly can best be provided through the established system.

Let us examine the situation as it stands today. Health insurance is being issued to older people now at a faster rate than for any other age group. Three times as many older people own health insurance today than ten years ago. Many companies, including our own, offer special policies to people over 65, and 53 per cent of the aged population not being cared for in institutions now own some form of health insurance.

As for the claim that retired people can't afford health insurance, or adequate medical care for themselves—let's look at the record. Seven out of ten couples receiving Social Security benefits own their own homes, and 87 per cent of these are free of indebtedness. Twenty per cent of the aged have \$5,000 or more in liquid assets, compared with ten per cent for the entire population.

What about those who really do need assistance? Elderly persons who cannot meet their living expenses can get medical care under existing old age assistance programs. In 1960 Congress passed the Kerr-Mills law which provides for federal aid to be administered at the state level on a matching funds basis, making medical care available for those who are able to meet regular living expenses but who do not have the resources to pay their medical bills.

The Kerr-Mills law requires implementation in the various states, and in the short time since it was enacted, 38 states have already implemented it or are in the process of doing so.

Proponents of the Social Security approach, such as in the King-Anderson Bill (H.R. 4222) now pending in Congress, argue that the "means test" required in the Kerr-Mills law is degrading. The facts are, without such a test, the nation could easily become bankrupt by paying out tax funds to people, regardless of their need. That is why we have a "means test" in our public housing programs, veterans' programs, and college scholarships, and in any well-run community assistance program, such as Red Cross or Community Chest.

We have given some of the reasons we oppose such measures as the King-Anderson Bill, because we believe it to be unnecessary.

We think it is undesirable for several reasons. In the first place, it is a long step in the direction of complete socialization of all medical services. As former Congressman Forand said of his bill, which was rejected by Congress, "If we can only break through and get our foot inside the door, we can expand the program after that."

Socialization, or nationalization, of medical services has been brought about in many other countries. In every case it has lowered the quality of medical care, it has brought over-utilization of hospital facilities, and it has caused people who really need medical treatment to have to wait in line while others who merely think they need it take up the time of over-worked physicians who have to see 80 or 100 patients a day.

Furthermore, the cost of the King-Anderson proposal is quite likely to be much more than current government estimates of \$1.1 billion the first full year. Insurance actuaries estimate the cost at more than double this in the first year. Ultimately, costs for this proposal may be as much as \$5.4 billion a year, according to our actuaries.

In this connection, it is interesting to note that when Great Britain socialized medicine the actual costs were five times the estimates made. And today, the average British patient stays in the hospital more than twice as many days as the average American patient stays in a private hospital here.

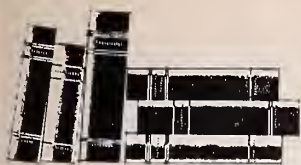
We have the best system of medical care in the world, and we have the means for taking care of all who need help through the voluntary system. Why should we risk the deterioration of our medical care by adopting a compulsory plan? Why should we tax the working man to provide medical care for millions who don't need it?

Already our country is finding it difficult to compete in the world market.

If we continue to add to the cost of producing our goods and services by unnecessarily adding to the burden of taxation on employers and employees, we may very well find ourselves priced out of the market.

If this happens, the Soviet Union will not have to defeat us—we will have defeated ourselves.

Reprinted from THE LOG, April 1962



BOOKS RECEIVED

Edited by Currie, Alastair R.; Symington, T.M., M.D.; Grant, J. K.; **THE HUMAN ADRENAL CORTEX**, The Williams and Wilkins Co., Baltimore, 1962, 644 pp., \$11.00.

Edited by Hamilton, W. F., and Dow, Philip, **HANDBOOK OF PHYSIOLOGY**, American Physiological Society, Washington, D.C., 1962, 758 pp., \$24.00.

Edited by Oppenheimer, Ernst, M.D., and Prepared by Netter, Frank H., M.D., **THE CIBA COLLECTION OF MEDICAL ILLUSTRATIONS, VOL. THREE, DIGESTIVE**; CIBA, New York, 1962, 243 pp., \$15.00.

Slaughter, Frank G., **TOMORROW'S MIRACLE**, Doubleday & Co., Garden City, New York, 1962, 306 pp., \$3.95.

Edited by Wolstenholme, G.E.W. and O'Connor, Maeve, **CIBA FOUNDATION, TUMOR VIRUSES OF MURINE ORIGIN**, Little Brown & Co., Boston, 1962, 441 pp., \$10.75.

Burch, George E., M.D., and DePasquale, Nicholas P., M.D., **PRIMER OF CLINICAL MEASUREMENT OF BLOOD PRESSURE**, The C. V. Mosby Co., St. Louis, 1962, 141 pp., \$5.50.

Artusio, Joseph F., Jr., M.D., and Mazzia, Valentino D. B., M.D., **PRACTICAL ANESTHESIOLOGY**, The C. V. Mosby Co., St. Louis, 1962, 318 pp., \$7.75.

Wells, Benjamin B., M.D., **CLINICAL PAHOLOGY, APPLICATION AND INTERPRETATION**, W. B. Saunders, Philadelphia and London 1962, 541 pp., \$9.00.

Edited by Bock, K. D., **SHOCK, PATHOGENESIS AND THERAPY**, Springer-Verlag; Berlin, Göttingen, and Heidelberg, 1962, 387 pp.

Major, Ralph H., M.D., and Delp, Mahlon H., M.D., **PHYSICAL DIAGNOSIS**, W. B. Saunders Co., Philadelphia and London, 1962, 355 pp., \$7.50.

Buxton, C. Lee, M.D., **A STUDY OF PSYCHOPHYSICAL METHODS FOR RELIEF OF CHILDBIRTH PAIN**, W. B. Saunders Co., Philadelphia and London, 1962, 116 pp., \$4.75.

O'Donoghue, Don H., M.D., **TREATMENT OF INJURIES TO ATHLETES**, W. B. Saunders Co., Philadelphia and London, 1962, 649 pp., \$18.50.

Flippin, Harrison F., M.D., **MEDICAL STATE BOARD QUESTIONS AND ANSWERS**, W. B. Saunders Co., Philadelphia and London, 1962, 507 pp., \$9.50.

Adler, Francis Heed, M.D., **TEXTBOOK OF OPHTHALMOLOGY**, W. B. Saunders Co., Philadelphia and London, 1962, 560 pp., \$9.00.

Engel, George L., M.D., **PSYCHOLOGICAL DEVELOPMENT IN HEALTH AND DISEASE**, W. B. Saunders Co., Philadelphia and London, 1962, 435 pp., \$7.50.

Green, Morris, M.D., and Richmond, Julius B., M.D., **PEDIATRIC DIAGNOSIS**, W. B. Saunders Co., Philadelphia and London, 1962, 541 pp., \$13.00.

Meyer, Ruben, M.D.; Levitt, Morton; Falick, Mordecai L., M.D.; Rubenstein, Ben O.; **ESSENTIALS OF PEDIATRIC PSYCHIATRY**, Appleton-Century-Crofts, New York, 1962, 208 pp., \$6.00.

Holt, L. Emmett, Jr., M.D.; McIntosh, Rustin, M.D.; and Barnett, Henry L., M.D., **PEDIATRICS**, Appleton-Century-Crofts, New York, 1962, 1395 pp.

REVIEWS

Graham, John B., M.D.; Sotte, Luciano, Sc., M.D.; and Paloncek, Frank, P., M.D.; **CARCINOMA OF THE CERVIX**, The W. B. Saunders Company, Philadelphia, Pa., 1962, 474 pp.

THIS TREATISE ON CANCER of the cervix represents a complete and excellent textbook on this subject. The book is well organized along lines of frequency, etiology, pathology, diagnosis, prognosis, and management. Separate chapters treat carcinoma of the cervix in situ and other borderline lesions, and carcinoma in pregnancy. There are also well illustrated chapters on radiotherapy, radiation physics, and surgical treatment.

A chapter on radiation complications is very realistic.

This book is excellently illustrated, and the graphs and charts are very good and informative.

This is a very complete book on the subject of cancer of the cervix.

Joseph L. Girardeau, M.D.

Lore, John M., Jr., M.D., F.A.C.S., Illustrated by Robert Wabnitz, **AN ATLAS OF HEAD AND NECK SURGERY**, W. B. Saunders Company, Philadelphia and London, 1962.

THIS BOOK consists of 17 chapters with outstanding illustrations of anatomy, and adequate, but not too detailed, description of operative and diagnostic procedures. In the first chapter there are seven sectional views of the head with x-rays indicating their relationships to the anatomy. This chapter would be of tremendous value for reference and evaluation of x-ray to determine the extent of fracture or tumor involvement of the skull and facial bones.

The diagnostic procedures of laryngoscopy, bronchoscopy, and esophagoscopy are described in the first portion of the section on general operative procedures. Each is accompanied by adequate illustration. This section also includes a description of the basic procedures of thoracotomy, tracheostomy, pharyngostomy, cardiac massage, and selected basic plastic procedures. The remaining chapters are divided into logical anatomical areas of the head and neck, each covering a wide variety of procedures ranging from the simplest to the most radical.

The manner of presentation in this book makes it of value to the resident needing a compact presentation of a procedure or the experienced surgeon desiring a quick review.

John T. Mauldin, M.D.

Florey, M.D. — **GENERAL PATHOLOGY**, W. B. Saunders Company, Philadelphia and London, 1962, \$22.00.

THIS is a 1104-page book devoted to general pathology. It is an attempt to present certain aspects of the reactions of the body to injury in a broad sense. There are 44 chapters as contrasted to the previous edition of 43 chapters.

Including Florey, there are 17 authors who are recognized authorities in their respective fields.

Physician's Bookshelf/Continued

This edition is embellished with excellent electron microscopic photographs. In addition, the added chapter concerns the Immunology of Tissue Transplantation.

This book is recommended for the pathologist, student, and clinician interested in the fundamental aspects of disease.

John Godwin, M.D.

McKusick, Victor A., M.D., **MEDICAL GENETICS: 1958-1960**, The C. V. Mosby Co., St. Louis, 1961, 534 pp., \$14.50.

THE REVIEWER of this compendium has the somewhat unusual task of "judging the judges." Dr. Victor McKusick, Professor of Medicine at The Johns Hopkins University School of Medicine, has brought concise reviews and criticisms of a great deal of the world's published experience pertaining to medical genetics, into a single volume covering the years 1958, 1959, and 1960. Each of these years is covered separately. Numerous reviews and abstracts appear under such headings as: new books, journals, symposia and congresses; history; selected reports of general genetics; general considerations of human genetics; statistical and biochemical methods; cytogenetics; biochemical genetics; and congenital malformations. The genetics of individual bodily systems comprise the remaining 16 chapter headings. An epilogue appears at the end of each year's reviews. References are complete and the index seems adequate. Sometimes the reviews are caustic and occasionally picayunish, but by and large the work is admirably and thoroughly done. The undertaking and the results are really phenomenal, and well worth while to those who plan to keep abreast of this rapidly changing subject. This seems to be, at least in the field of medical genetics, Mosby's answer to the Year Books of other fields.

John Rhodes Haverty, M.D.

Davison, Wilburt C., M.D., Professor of Pediatrics, Duke University Medical Center, and Levinthal, Jeana Davison, M.D., Research Associate, Harvard Medical School, **THE COMPLETE PEDIATRICIAN**, Seeman Printery for Duke University Press; Durham, N. C., 1961, \$4.50.

DR. DAVISON, by his careful scholarship, has again supplied those physicians concerned with the care of children an excellent compendium on pediatrics.

His emphasis has been more to supply perspective and depth than to give extensive documentation. Furthermore, by bringing his work up to the present, he has made a practical handbook to which the practitioner can turn to discover current practice.

Preston D. Ellington, M.D.

Simpson, Keith, M.D., **FORENSIC MEDICINE (Fourth Edition)** Williams & Wilkins Co., Baltimore, 1961, 341 pp., \$7.50.

THE AUTHOR is an English physician whose title is somewhat misleading to Americans. "Forensic Pathology and Toxicology" might be a more informative title for a very excellent standard textbook on those subjects.

The author's approach is extremely practical with frank advice freely given to the medical student on what to do with a dead body if he is the first responsible person on the scene. The text is as lucid as possible and the examples numerous, briefly stated, and always helpful. The author emphasizes practical hints to help in distinguishing the clearly non-criminal scene from a scene requiring notification of the public authorities. The young physician will learn from this book that there is to be no foolishness with respect to a practicing physician's public duties. At the same time he can learn the extent to which he will be obliged to spare family humiliation and public expense.

From an American's viewpoint the text suffers slightly by extensive reference to English and Scottish laws regarding certification of death, birth, insanity, and the like. However, the procedures are all analogous and little is thereby lost.

John L. Moore, Jr.

AMA OPPOSES CHIROPRACTIC EXTENSION UNDER FEDERAL ACT

The American Medical Association opposed legislation that would permit beneficiaries of the Federal Employees' Compensation Act to utilize services of chiropractors.

In a letter to the chairman of the Senate Subcommittee on Employees Compensation, Dr. F. J. L. Blasingame, AMA Executive Vice President, said:

"Chiropractic is a pseudo-science which is not based on scientific methods and, therefore, should be recognized as what it is—a theory of cultism. It is premised on the theory that human illness is all related to the spinal column. It holds that the nerves that emanate from the spinal cord become impinged or "pinched by the vertebrae, thereby causing malfunction and disease."

"As a result of this theory, chiropractors claim that disease and illness such as allergies, diabetes, heart trouble and tonsillitis, to name a few, can be cured by adjusting or manipulating the spinal column. Such a theory, of course, runs counter to the established facts of medical science.

"Chiropractors are not educated or equipped by either background or training to diagnose human illness. This inability to render a diagnosis, coupled with their pseudo-scientific method of treatment, when taken into consideration in connection with their vociferous stand against life-saving vaccines and wonder drugs, precludes that any consideration be given them."



Rooney, Donald R., M.D., Kennestone Hospital, Marietta, Georgia, "Vesicoureteral Reflux in Children," Am. J. Roentgenol. 86:545-555 (Sept) 61.

Many pediatricians and other physicians have been faced with the problem of the young child who has unexplained, recurring episodes of pyuria and fever. The management of these children is often confusing and difficult since repeated excretory urograms and cystoscopic exams fail to demonstrate any abnormalities. In the past two years at Kennestone Hospital, 128 children with recurring urinary symptoms received cystograms in addition to the usual studies. Many of these problem cases were found to have marked vesicoureteral reflux.

Vesicoureteral reflux is not observed in normal unanesthetized children without other evidence of urinary disease. Reflux is an abnormal occurrence and is a reliable indication that there is an underlying urinary tract disorder. Persistent untreated reflux may lead to progressive and irreversible urinary tract damage. There are several causes for reflux. Most children are found to have an obstructing lesion at or below the bladder neck which is not demonstrated on excretory urograms or cystoscopic examinations. Three-fourths of children with reflux have normal excretory urograms.

The presence of vesicoureteral reflux can be simply and quickly demonstrated in any radiology department with no special equipment. Four films are usually obtained, being certain to completely include the kidney and bladder areas. A survey film of the abdomen is made, being certain that no contrast material is present from previous studies. Using strict aseptic technique, a small simple catheter is inserted into the bladder. The bladder is emptied and this urine may be saved for cultures or other studies. Approximately 150cc of dilute Hypaque is allowed to flow into the bladder. As soon as the injection is completed, a second film is made. If bilateral reflux has occurred, the examination is terminated with only these two films. If not, a delayed film is obtained after 20 minutes. Following this, the child is allowed to void, and a voiding or immediate post-voiding film is obtained. It is important that the examination not be performed under anesthesia.

In a two-year period at Kennestone Hospital, 128 children with urinary symptoms have had cystograms. Thirty-eight children were found to have reflux. In 13 of the 36 children, reflux was bilateral. Every child with unexplained recurring urinary problems deserves a complete urological evaluation which should include a properly performed cystogram. If the radiologist routinely obtains cystograms of these children, his efforts will be rewarded with the demonstration of reflux in

perhaps 30 per cent of them and with the knowledge that many of these children may be spared the ravages of progressive renal damage.

Therapy is directed toward eliminating the underlying lesion and the reflux. Conservative therapy is tried first. In persistent cases, bladder neck revision and vesicoureteroplasty may be necessary. Effective therapy is available for many children with reflux; therefore, radiologists should make every effort to demonstrate this abnormal finding.

Scott, Morgan E., M.D., P.O. Box 459, Atlanta, Georgia, "The Development of Phobias," South. M.J. 54:1022-1025 (Sept) 61.

In human adaptation, with its prolonged period of dependency, there are fears in every infant related to the actual inability to meet environmental demands. As the child grows, the manner in which new situations are managed results in either the mastery of fear or its continuance.

Many cases derive from blocked impulses, sexual or aggressive, but other blocked impulses are equally often found. Often the phobia is established by non-verbal behavior.

Some patients do not respond to individual psychotherapy. Group therapy, with the group consisting of members sufficiently varied to give a number of issues and yet similar enough to give each other support, is proving beneficial. The group meets once weekly in one and one-half hour sessions and is composed usually of six members. The purpose is to attain a level of cohesiveness where mutual analysis is promoted and topics presented to the group are subjected to group interpretation. As phobias are generally immature, frequently overdependence on the therapist hinders progress. In a group situation the dependence on the therapist is limited.

Clippinger, Frank W., Jr., M.D., Dept. of Surgery, Duke University Medical Center, Durham, North Carolina, and E. C. Irwin, M.D., Manchester, Georgia, "The Opponens Transfer," South. M.J. 55:33-36 (Jan) 62.

Muscle tendon transfer to restore opposition to the thumb can be carried out either by utilization of a flexor digitorum sublimis transferred to the thumb directly or by means of a carpal flexor or extensor prolonged by a free tendon graft. Compared to the direct tendon transfer, the free tendon graft will not give as consistently good results because of the tendency for limitation of excursion of the graft. The technique of carrying out the procedure of opponens transfer is discussed, and the pitfalls contributing to imperfections are pointed out. Other than limitation of excursion, the most common of these are hyperextension of the metacarpal phalangeal joint of the

thumb which may be prevented by proper insertion of the tendon distal to the joint and flexor contraction of the donor finger in case of a direct sublimis transfer. This latter may be prevented by gentle handling of the sublimis tendon while it is being detached plus splinting of this finger in extension, followed by early mobilization. In this series approximately 80 per cent of the direct sublimis transfers produced satisfactory results, while only 40 per cent of the free tendon grafts lived up to expectation.

Bryant, Milton F., M.D., Medical Arts Building, Atlanta, Georgia, "Surgical Treatment of Cerebral Vascular Insufficiency," Supplement to Ann. Surgery 154:182-186 (Dec) 61.

Considerable experience has now been accumulated which shows that many patients with cerebrovascular insufficiency have stenotic or occlusive lesions in the extracranial portion of one or more of the four major arteries that supply the brain. For all practical purposes atherosclerosis is the usual cause of these obstructive lesions. The most common site of atherosclerotic involvement is in the proximal portion of the internal carotid artery. The physical findings associated with obstruction in the internal carotid artery vary and are related to abnormalities in the blood vessels and to the resultant damage to dependent brain tissue. Ophthalmodynamometric studies are occasionally helpful in determining the site of obstruction. Arteriograms are necessary to establish the diagnosis.

Patients with symptoms of cerebral vascular insufficiency due to segmental atherosclerotic lesions in the base of the internal carotid artery can frequently be treated by thromboendarterectomy. An aggressive approach, including arteriography in many instances, to the problem of recurrent focal cerebral ischemic attacks and to strokes in general is essential in order to outline the best treatment program for each patient.

Hasenhuttl, Kurt, M.D., 310 Doctors Building, Columbus, Georgia, "Osteopetrosis," J. Bone & Joint Surg. 44A:359-370 (March) 62.

Osteopetrosis is a relatively rare bone disease with 257 reported cases. The first long term follow-up study, 24 years, has been reported in a 27 year-old white male. The most conspicuous feature of this disease is wide-spread involvement of the skeletal system with increasing sclerosis of the bones. Encroachment of the right optic foramen caused blindness of the right eye. The hip joints showed coxa vara deformity. Multiple fractures—33—most of them transverse, were distributed uniformly throughout 24 years. The humeri and femora broke in the proximal third.

ABSTRACTS / Continued

forearm bones broke distally. Fracture healing was normal, except the right forearm, the site of numerous fractures leading to marked deformity. Laboratory tests were normal, except a gradual decline in the hemoglobin and hematocrit since adolescence.

The cause of this congenital bone disease is not known; a faulty intrauterine development of bones can be demonstrated. Consanguinity in parents was present and might be a contributing factor. Patient has benign form of osteopetrosis; survival into adulthood without involvement of liver, spleen and lymph nodes confirms it.

The severe skeletal changes have not been detrimental to patient's general health. Prognosis for longevity must be guarded, as impaired function of the bone marrow has been found.

Holde, Puchler, M.D., and Sweat, Faye H. T., Medical College of Georgia, Augusta, Georgia, "Amidoblack as a Stain for Hemoglobin" Arch. Path. 73:245-249 (March) 62.

The tannic acid—phosphomolybdic acid—amidoblack method (TPA method) was developed as a stain for terminal bars and related structures. This method has now been modified so that hemoglobin is stained selectively.

Paraffin sections, fixed or mordanted in Zenker-formol (Spuler, Maximow) were treated consecutively with tannic acid, phosphomolybdic acid, and amidoblack 10B in methanol—glacial acetic acid. Erythrocytes, intravascular as well as in hemorrhages, hemoglobin casts, and intracellular hemoglobin droplets were colored dark blue, all other tissue structures yellow. Hemosiderin and bile casts in liver and kidney did not bind amidoblack.

The selectivity of the TPA method for hemoglobin is indicated by model experiments with pure hemoglobin and methemoglobin, fibrinogen, gelatin, and fractions of human serum proteins separated by paper electrophoresis. Only hemoglobin and methemoglobin reacted with amidoblack. The TPA method does not permit distinction between hemoglobin and methemoglobin.

(Supported by USPHS Grant No. RG-7303, and Medical College of Georgia Professional Research Fund Grant No. 51-79.)

Chambless, William H., M.D., Montgomery, A'abama, and Florence, Thomas J., M.D., 340 Boulevard, N.E., Atlanta, Georgia, "Midline Preperitoneal Approach to Undescended Testes and Inguinal Hernia Repair" J. Internat. Coll. Surgeons 36:732-741 (Dec) 61.

Because of dissatisfaction with standard anterior approaches to surgical correction of cryptorchidism and inguinal hernias, we have approached the posterior inguinal region by a midline posterior approach.

After autopsy dissections, we utilized this approach in 25 cases of undescended testes, unilateral and bilateral, for successful placement into the scrotum through the rectus structures. Dissection was accomplished from the internal ring, where most cryptorchids lie, to

the kidney region in order to lengthen the cord. Concomitant indirect hernias were repaired.

In indirect, direct, femoral, sliding, and recurrent inguinal hernias, bilateral hernioplastys were done in thirty cases by this posterior approach. Strangulated hernias, age, obesity, and size of hernias were contra-indication to this Cheatle-Henry approach (used originally only for femoral hernias). Indirect hernias were repaired by high ligation and snugging the internal ring crura. Direct and femoral defects were repaired by approximating the ileopubic tract or Cooper's ligament to the medial thickened transversalis fascia. Usually, defective internal ring and direct defects were both found.

No recurrence nor major complications have been noted in six-months follow-ups. We advocate this approach for large unilateral hernias.

Ease of dissection, excellence of exposure, and shortened operative time favor this preperitoneal midline posterior approach.

Yeh, Thomas J., M.D.; Ellison, Lois T., M.D.; and Ellison, Robert G., M.D., Medical College of Georgia, Augusta, Georgia, "Hemodynamic and Metabolic Responses of the Whole Body and Individual Organs to Cardiopulmonary Bypass with Profound Hypothermia," J. Thoracic & Cardiovasc. Surg. 42:782-792 (Dec) 61.

Hemodynamic and metabolic changes were studied in 16 dogs subjected to total body perfusion at various flow rates combined with profound hypothermia of 5° to 10° C. In addition, 10 dogs were perfused in a similar manner, and venous blood from various organs was analyzed. Diminution of venous return was noted during cooling. Pooling of blood in intravascular space, particularly in the portal bed, was exaggerated when high flow rates were used. Arteriovenous oxygen saturation difference narrowed with cooling but, even at esophageal temperature of, 5° C, tissues continued to consume oxygen. With high flow perfusion, final pH was altered only slightly, but, with low flow perfusion, metabolic acidosis developed or was accentuated in spite of seemingly adequate flow, as judged by elevated venous oxygen saturation. In hypothermic perfusion, venous oxygen saturation is not a satisfactory monitor for adequacy of flow. Muscle mass and brain cooled slower than other organs. Femoral venous oxygen saturation was lower than the other samples during perfusion. The possible causes of acidosis which develop after hypothermic perfusion were discussed. In order to avoid serious metabolic acidosis during hypothermic perfusion, it appears desirable to adjust flow to the maximum possible without seriously exceeding available venous return.

Hughston, Jack C., M.D.; Whatley, George S., M.D.; and Dodelin, Richard A., M.D., 1316 Thirteenth Avenue, Columbus, Georgia, "The Athlete and His Knees," South. M.J. 54:1372-1378 (Dec) 61.

In summary of this series of 100 cases, the ratio of tears of the medial meniscus to those of the lateral meniscus is three

to one. 25 per cent of the patients exhibited chondromalacia of the patella; 42 per cent demonstrated a torn anterior cruciate ligament. Only one-third of these (11 cases) with torn anterior cruciate ligaments demonstrated positive drawer signs in the preoperative examination. We suspect this would not be true in a nonathletic group. In one half of these (21 cases) the patient with torn anterior cruciate ligaments returned to full athletic activity without symptoms of pain, swelling or giving away. 66 per cent of all players returned to full athletic activity. Of the 34 per cent not returning to athletics, eight per cent are known to have knees which would not tolerate full athletic activity after corrective surgery. 12 per cent did not have the opportunity to return to athletics. In the remaining 14 per cent it is not known whether the patients had the opportunity of returning to athletic competition.

Early diagnosis is the key to recovery of the injured knee. Early diagnosis is dependent upon the coach or trainer getting the patient to the doctor promptly. Early diagnosis is then dependent upon the physician being alert enough to evaluate the extent and type of injury. A major difficulty with knee injuries remains in the lack of adequate diagnosis at the time of initial injury.

Watch the game and see the injury!

Logan, William D., Jr., and Crispin, Roy H., M.D., 340 Boulevard, N.E., Atlanta 12, Georgia, "Hereditary Hemorrhagic Telangiectasia with Pulmonary Arteriovenous Fistula" South. M.J. 55:29-32 (Jan) 62.

Two cases of hereditary hemorrhagic telangiectasia associated with pulmonary arteriovenous fistulas are reported. One case had three A-V fistulas in the right lung and one small fistula in the left lung. All three lesions in the right were resected with segmental resection. This resulted in a disappearance of the patient's polycythemia. The other cases revealed the presence of a large thrombus in the fistula. Whether this was originally an embolus or a primary thrombus is not apparent. The patient was fortunate that the clot remained here rather than migrating elsewhere in the arterial circulation.

The history and incidence plus clinical aspects and diagnosis are discussed.

The importance of better understanding and knowledge of this condition is stressed. The association of pulmonary A-V fistula in hereditary hemorrhagic telangiectasia is a very real one. Further studies will probably reveal a higher percentage than previously reported. The inherent dangers of bleeding, cerebral emboli, and polycythemia are always present. There has been previous speculation that subsequent arteriovenous fistulas will develop if the existing ones are removed. Only longer follow-up evaluations will answer this. At present surgery should be considered in all cases of significant pulmonary arteriovenous fistula.

Brown, Lester A., M.D., 490 Peachtree Street, N.E., Atlanta 8, Georgia, "Slaves to Antimicrobials," *Arch. Otolaryng.* 75:95-96 (Feb) 62.

The author decries the indiscriminate use of the antimicrobial medications which are administered so often when there is no obvious infection or evidence of impending infection. He especially refers to "clean" surgery, such as operations on the noninfected ear for the improvement of hearing where the deafness has been caused by otosclerosis which is not concerned with infection. Overlooked is the fact that the normal human organism has a tremendous faculty for healing, that (as a rule in "clean" surgery) no laboratory determination of existing organisms has been made before ordering the antimicrobial drug, that the patient may become severely ill from personal sensitivity to the drug, that no more than routine thought is given to one's own antiseptic surgical technique, and, most important, that those doctors who do not use the antimicrobials routinely, have no higher infection rate.

Finally, the author believes that the procedure of indiscriminately giving antimicrobial medication following "clean" surgery can only develop a situation of false security. It could hardly be anything more or less than haphazard therapy.

Harrison, J. Harold, M.D., and Davalos, Pablo A., M.D., 490 Peachtree Street, N.E., Atlanta 8, Georgia, "Cerebral Ischemia," *Arch. Surg.* 84:85-94 (Jan) 62.

Thirty-six of 212 patients evaluated with arteriography by the authors during the past three years had cerebral vascular insufficiency of varying degrees produced by buckling due to tortuosity of their major cerebral vessels. 30 patients had 34 lesions corrected by surgery.

Ten patients with buckles of the carotids were admitted with hemiplegia. Symptoms in the others varied from transient bouts to progressive cerebral ischemia. The most frequent deformities were S-shaped curves; others formed loops, while three had only minimal tortuosity with V-shaped indentations. Superimposed thrombosis and complete occlusion were present in three.

The buckled areas were released of their fibrous bands. In most, the external carotid arteries were ligated and segments of the common carotids resected. In others sections the internal carotids were removed or they were divided and anastomosed end-to-side to lower levels of the common carotids, preserving the external carotids and carotid sinuses. Tortuosity of the innominate and carotid arteries was corrected by resection of a portion of the common carotid.

Buckles of the first portion of the left vertebrals were corrected by transposing the subclavian artery anterior to the jugular vein and carotid artery, thus forming a sling.

Nine of the ten patients with hemiplegia cleared almost completely and the other had partial return. Those with progressive symptoms cleared and

there have been no further bouts in the ones with transient symptoms. There was one death attributable to surgery. Patients with vertebral buckles were improved, but the number is not sufficient to draw conclusions.

The results of this series indicate the frequency and importance of recognition of buckles due to tortuosity, particularly of the carotid arteries. Physical findings in the vessels are usually absent, and diagnosis can be made consistently only by arteriography. Surgery is relatively atraumatic and good results can be expected in most cases.

Stone, H. Harlan, M.D., and Jones, H. Quillian, M.D., "Penetrating and Non-penetrating Injuries to the Ureter," *Surg. Gynec. & Obst.* 114:52-56 (Jan) 62.

Seven cases of penetrating wounds to the ureter are presented. An additional case of rupture of the ureter, secondary to blunt abdominal trauma, is presented with a summary of eight similar cases taken from the English literature. Early recognition of these injuries is stressed. Pre-operative diagnostic studies and operative findings are mentioned. Basic principles of ureteral repair are briefly outlined.

Kiger, Robert G., M.D., Talmadge Memorial Hospital, Augusta, Georgia, "Observations on the Symptomatic Treatment of Porphyria with Valethamate Bromide," *South. M.J.* 55:154-155 (Feb) 62.

Two cases of intermittent porphyria are reported whose symptoms were dramatically relieved by valethamate bromide (generic name for "Murel"). One case simulated an acute abdomen. The other case suffered from peripheral neuropathy. A double blind study was performed on the latter using valethamate bromide and placebo. Improvement correlated with drug administration in each case.

Presumably this drug acts through its anticholinergic effect similar to atropine, myotropic effect greater than papaverine and ganglionoplegic action. Its relative low toxicity and effectiveness in these two suggests its usefulness in similar cases.

Sikes, Z. S., M.D., 492 New Street, Macon, Georgia, "Frenquel Corrects EEG Changes and Relieves Symptoms in Porphyria," *Dis. Nervous System* 22:695-696 (Dec) 61.

The paper refers to several articles describing electroencephalographic changes seen during crises in Intermittent Porphyria. The EEG changes, as well as psychiatric symptoms of Porphyria, are compared to those produced by Lysergic Acid Diethylamide and mescaline. Since the EEG changes as well as the psychic symptoms in the experimental psychoses are reversed by administration of Frenquel, the author felt that Frenquel should be tried therapeutically in Porphyria.

A clinical case of Porphyria was described, the symptoms including headache, abdominal pain, motor restlessness and weakness of the lower extremities. While his urine was positive for porphobilinogen in 1:160 dilution, Frenquel was administered intrave-

nously and orally and an EEG proved to be normal. During a previous attack his EEG had shown the characteristic slow-wave pattern. In addition, the symptoms were dramatically relieved. During a period of follow-up over several months, even though the patient was not entirely symptom free on Frenquel, he was able to work regularly.

Two possibilities in the production of at least part of the clinical syndrome are direct interference with neuronal metabolism or a serotonin-enhancing mechanism of porphyrins.

Okel, Benjamin B., M.D., and McLean, Ross L., M.D., Emory Hospital, Atlanta 22, Georgia, "Tuberculous Peritonitis in the Chemotherapy Era," *South. M.J.* 55:156-159 (Feb) 62.

A review of 38 cases of tuberculous peritonitis at Grady Memorial Hospital and the Atlanta V.A. Hospital during the period of 1948 through 1959, revealed a striking prevalence of this disease in the Negro race. The most common presenting symptoms were abdominal swelling, abdominal pain, weight loss, and fever. The most usual physical signs were fever (97 per cent of cases in this series), abdominal tenderness, and evidence of ascites. From this series it is evident that relapse is likely in individuals receiving less than four months of chemotherapy. Optimum drug combinations, dosages and duration of chemotherapy remain to be established. However, on the basis of experience with pulmonary tuberculosis, original cases should do well on isoniazid, 200 to 300 milligrams daily, combined with either PAS, eight to 16 grams per day, or Sterptomycin, one gram per day maintained continuously for not less than 90 days or until signs of active disease have disappeared. Thereafter, isoniazid alone in 200 to 300 milligram doses should be continued for not less than one year. The importance to proper management of a definitive tissue and/or bacteriologic diagnosis is stressed.

Upshaw, Charles B., Jr., M.D., U.S. Army Hospital, Ft. McPherson, Georgia, "Congenital Coronary Arteriovenous Fistula," *Am. Heart J.* 63:399-404 (March) 62.

A case of left and right coronary artery-right ventricle fistula is presented. The literature is reviewed and brought up to date on this subject. These fistulae are classified according to the heart chamber into which they empty. They usually originate from one coronary artery, but not infrequently they originate from both. The latter situation is most likely to occur when the fistula empties into either the right ventricle or the pulmonary artery.

Of the 65 patients studied, 22 had congenital coronary arteriovenous fistula associated with some other congenital cardiovascular defect. These were classified into six groups. Particularly striking was the association of coronary arteriovenous fistula and pulmonary valvular atresia (ten cases); patent ductus arteriosus was an associated lesion in seven of these and ventricular septal defect in three. Patent ductus arteriosus was associated with congenital coronary

ABSTRACTS / Continued

arteriovenous fistula in ten of the 65 cases.

Of 23 patients who have been operated upon and reported upon to date, one patient died and one was not improved; four suffered major operative or postoperative complications. Yet 20 of the 23 recovered and were improved.

Vogler, William R., M.D.; Lloyd, J. William, M.Sc.; and Milmore, Benno K., M.D., Emory University School of Medicine, Atlanta 22, Georgia, "A Retrospective Study of Etiological Factors in Cancer of the Mouth, Pharynx, and Larynx," *Cancer* 15:246-258 (Mar-Apr) 62.

Queries relating to occupation, history of syphilis, nutritional deficiency, family history of cancer, use of dentures, tobacco, and alcohol were obtained from 1,958 white out-patients at the Robert Winship Memorial Clinic, Atlanta, Georgia. Four Diagnostic groups were established: 1. Cancer of the mouth, pharynx and larynx (235 males and 98 females); 2. Mouth examined, other diseases or no disease found (214 patients); 3. Cancer of other sites, mouth not examined (584 patients); 4. No cancer, mouth not examined (787 patients). Data in each group were adjusted for age, sex, and residence and subjected to statistical analysis.

In group one, cancer originated in the mouth proper in 91 per cent of the females and 60 per cent of the males. The remainder arose in the lips, pharynx, and larynx. Most of the mouth cancers were low-grade, squamous cell carcinomas frequently multiple and often associated with leukoplakia. The use of tobacco in forms other than cigarettes was significantly more frequent in the study group. This was most striking regarding chewing tobacco in males and snuff in females. A highly significant correlation was found between the use of snuff and cancer of the buccal cavity.

There was no significant difference between the study and control groups with regard to consumption of alcohol.

Some differences were found in the alcohol consumption within the study group. Data failed to confirm a relationship between mouth cancer and presence and fit of dentures, nutritional deficiencies, occupation, history of anemia, family history of cancer or syphilis.

Kagan, Irving G., Ph.D.; Rairigh, Donald W., M.D., and Kaiser, Robert L., M.D., Microbiology Section, C.D.C., Atlanta 22, Georgia, "A Clinical Parasitologic and Immunologic Study of Schistosomiasis in 103 Puerto Rican Males Residing in the United States," *Ann. Int. Med.* 56:457-470 (March) 62.

In a study of 103 Puerto Rican prison inmates using various clinical and laboratory methods, 29 were found to harbor eggs of *Schistosoma mansoni* and 45 showed positive skin test reactions. The following conclusions were reached: Chronic schistosomiasis, the form seen most often in the U.S., is relatively asymptomatic with few physical findings; schistosomiasis should be suspect in individuals born or residing in Puerto Rico since approximately one-third of the sample studied here was infected; routine laboratory findings are of little aid in establishing a diagnosis; the skin test is a valuable screening tool; good correlation is found between serologic and parasitologic findings; schistosomiasis should not be rejected until a negative skin test, two or three negative stool examinations using concentration techniques, and a negative rectal biopsy have been obtained; with a positive skin test and repeated negative stool examinations or negative rectal biopsy, infection is probably light or has terminated and treatment is not warranted; however, if eggs are demonstrated, treatment is recommended to minimize hepatic-pulmonary complications.

Su, Cheng-Tsuau, M.D., and Prince, Charles L., M.D., 2515 Habersham Street, Savannah, Georgia, "Melanoma of the Bladder," *J. Prol.* 87:365-367 (April) 62.

Melanoma of the bladder is a rare but rapidly fatal disease. The pertinent literature is reviewed. Only 13 cases

have been reported to date. Two additional cases are reported. In all but two of the reported 15 cases, the involvement of the bladder by melanoma was secondary. The case reported by Wheelock and our first case were thought to be a primary melanoma of the bladder. However, this diagnosis could not be definitely established since necropsy was not performed. The diagnosis of primary melanoma of the bladder must be made with caution, since there is always the possibility that a small, unrecognized lesion may pre-exist. A speculation is made that secondary melanoma of the bladder occurs considerably more frequently than is reported.

Hand, Robert A., M.D., and Chandler, A. Bleakley, M.D., Medical College of Georgia, Augusta, Georgia, "Atherosclerotic Metamorphosis of Autologous Pulmonary Thromboemboli in the Rabbit," *Am. J. Path.* 40:469-486 (April) 62.

In this experiment, new support was obtained for the concept of "thrombotic atherosclerosis"—the hypothesis that atherosclerotic plaques may be produced by a natural process of degeneration and organization of arterial thrombi or thromboemboli.

In principal the experiment consisted of injecting thrombi (not stasis clots) into the pulmonary arteries of 48 rabbits and observing the changes in the thromboemboli by killing the animals at serial intervals.

In the pulmonary arteries the thrombi became eccentric, fibro-fatty atherosclerotic plaques. During the first week, a vascular inflammatory reaction was prominent and lysis of erythrocytes and granulocytes was conspicuous; the retracting thrombi became endothelialized. In succeeding weeks, fibrocytes derived from endothelial cells laid down coarse layers of collagen. Lipophages appeared and increased in numbers. These were derived from monocytes within the thrombi, principally by phagocytosis and digestion of blood platelets. Calcification of unphagocytized platelets was demonstrable after three weeks, and at 12 months bony metaplasia had taken place.

These plaques fulfilled the gross and histological criteria for atherosclerosis.

CENTER FOR TREATMENT OF BIRTH DEFECTS OPENED JULY 1

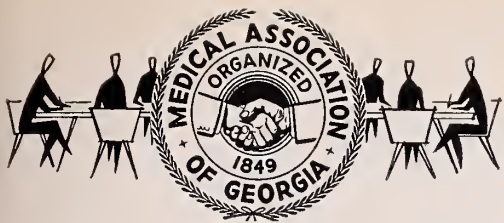
The Fulton-DeKalb Chapter of the National Foundation is sponsoring a special treatment center for birth defects at Emory University Hospital. It opened July 1.

In addition chapter officials gave Emory a \$22,318.00 grant for a special study of birth defects by Dr. William G. Thurman, Assistant Professor of Pediatrics at Emory Medical School.

The Fulton-DeKalb Chapter has committed \$30,000.00 to the birth defects center. After the center is opened for

patient care, final plans for the operation of the center will be announced by Dr. Richard Blumberg, Chief of Pediatrics at Emory.

Under the research grant, Dr. Thurman and his associates will obtain blood specimens from all premature babies born at Grady Hospital and all babies born with obvious birth defects. The samples from premature babies will be stored. If a birth defect becomes evident in any of the infants, the sample will be checked for protein abnormalities.



THE ASSOCIATION

DEATHS

CHARLES USHER, 83, of Savannah died May 13, 1962, at Memorial Hospital, Savannah. Dr. Usher, a native of Springfield, graduated from the University of Georgia School of Medicine. He served his internship at the University Hospital in Augusta and did postgraduate work at New York Polyclinic. A former president and chief of staff of Warren Candler Hospital, Dr. Usher specialized in surgery and was chief of staff of the old Parkview Sanitarium.

Dr. Usher, a past president of the Georgia Medical Society, was a member of the Medical Association of Georgia, and the American Medical Association, and was a past secretary and a president of the First District Medical Society and a fellow of the American College of Surgeons.

A 32nd-degree Mason, he was a life member of Solomon's Lodge, Allee Temple, and the Shriners. Dr. Usher was a member of the Bethel Lutheran Church and served as a first lieutenant in the Army Medical Corps during World War I.

Dr. Usher, himself the last surviving member of a family of 12 children, is survived by his wife, Rose Smith Usher; two sons, Dr. Charles Usher, Jr., and Jack H. Usher; a daughter, Mrs. Beverly B. Jones of Miami, Florida, and nine grandchildren.

JOHN BAXTER DUNCAN, Atlanta, died at his home May 15, 1962. Dr. Duncan, 71, obstetrician, and chairman of the medical advisory board of the Cerebral Palsy School, was a member of the staff of Piedmont Hospital.

Born in Macon, he was a graduate of Johns Hopkins University. He practiced in Roanoke, Virginia, and Cleveland, Ohio, before establishing practice in Atlanta in 1921.

He was a member of the Episcopal Church, Fulton County Medical Society, Capital City Club, Piedmont Driving Club, and the Buckhead Lions Club.

Dr. Duncan is survived by his wife, Blanche Upshaw Duncan, and a sister, Mrs. Rodney F. Cohen of Augusta.

J. C. STONE, 81, of Doerun, died at his home May 15, 1962. He practiced medicine actively for 52 years in the Doerun area. Dr. Stone graduated from the University of the South Medical School and began practice in Doerun in 1908.

In 1914 the *Journal of the American Medical Association* credited him as the third physician on record to achieve a postmortem birth delivery.

Dr. Stone was a member of the Doerun Methodist Church, the Medical Association of Georgia, the American Medical Association, the Southern Medical Association, and was a life member of the Colquitt County Medical Society.

Surviving Dr. Stone are his widow, May Van Harrell Stone; three daughters, Mrs. Charles Brown and Mrs.

Rosa S. Tante, Doerun, and Mrs. James Hegidio, Vienna; one brother, Dr. Albert H. Stone, Fort Gaines; a sister, Mrs. E. D. Bacon, Doerun; and five grandchildren.

JAMES ANDREW THRASH, 69, of Columbus, executive director of the Medical Center of that city, and the Muscogee County Health Commissioner, died May 21, 1962, at the Medical Center. During his 42 years in public health he was responsible for the first countywide tuberculosis vaccination program in the country, the first communitywide insect control spray program, improvement in sanitation, and a countywide polio vaccination program.

Dr. Thrash received his medical degree from Emory University School of Medicine at Atlanta. After practicing medicine in Greenville from 1914 to 1917, and serving in the World War I Medical Corps, Dr. Thrash interned for a year at St. Bernard's Hospital in Chicago.

He was a fellow of the American Public Health Association, and a diplomate of the American Board of Preventive Medicine and Public Health.

Dr. Thrash served as president of the Georgia Public Health Association and was president of the Georgia Hospital Association.

Surviving Dr. Thrash are two sons, Lt. Col. James A. Thrash, Jr. of Maxwell Field, Montgomery, Alabama, and Willis S. Thrash, Administrator of South Highland Infirmary, Birmingham, Alabama; a brother, Thomas A. Thrash, Memphis, Tennessee, and four grandchildren.

SOCIETIES

BALDWIN COUNTY MEDICAL SOCIETY met May 22, 1962, at Milledgeville. Dr. W. H. M. Weaver, Macon, spoke on Hypothyroidism.

THE GEORGIA MEDICAL SOCIETY met in Savannah on June 12, 1962. The Savannah Chamber of Commerce presented the program.

GLYNN COUNTY MEDICAL SOCIETY met at Brunswick on May 22, 1962. Dr. Albert H. Wilkinson, pediatric surgeon from Jacksonville, Florida, spoke on intestinal obstruction in the newborn.

LAURENS COUNTY MEDICAL SOCIETY met on May 29, 1962, in Dublin. A program concerning the rise of Communism in Cuba was presented by three Cuban physicians, the Doctors Valdes, Garcia, and Barnta.

SOUTH GEORGIA MEDICAL SOCIETY met in Valdosta on June 12, 1962. Dr. Morgan E. Scott, Assistant Professor of Psychiatry at the Emory University School of Medicine at Atlanta, presented a talk entitled, "The Integration of Psychiatry and Medicine."

DOUGHERTY COUNTY MEDICAL SOCIETY sponsored the annual Southwest Georgia Medical Seminar held May 17, 1962 in Albany. A series of lectures

was presented by five Emory University medical specialists. A wide range of subjects was reported on by J. D. Martin, Atlanta; Gordon Davis, Sylvester; W. G. Elliott, Cuthbert; J. W. Hurst, Atlanta; and Ralph Roberts, Fitzgerald. Heart disease, inflammatory kidney disease in children, recent developments in the treatment of burns, and the latest developments in the management of pregnancy were several of the topics discussed.

TROUP COUNTY MEDICAL SOCIETY met March 21, 1962, in LaGrange. Dr. Earle E. Lewis, LaGrange, presented a talk on the various types and classifications of anemia with high points regarding the characteristics of each.

PERSONALS

First District

J. M. BYNE, Waynesboro, has been named Chairman of the State Board of Health succeeding J. G. WILLIAMS of Atlanta. Having been elected in May, Dr. Byne took office June 14, 1962.

The American Board of Obstetrics and Gynecology has certified JOHN J. DOOLAN, Savannah, as a diplomate.

In May, CLARENCE BUTLER of Columbus, spoke at Savannah to the First District of the Georgia Heart Association, sighting the fact that more money is spent on cosmetics than on medical research, and that heart disease, where more research is needed, is the number one killer.

The Lord Effingham Society of Springfield had as speaker for their May meeting T. A. PETERSON of Savannah. Dr. Peterson spoke on proposed medical care for the aged.

Second District

No news submitted.

Third District

J. C. SERRATO, JR., Columbus, spoke in May to the Sertoma Club. His talk highlighted the projects of the Latin American Studies Group of which he is Vice-President and Coordinator General.

FRANK B. SCHLEY of Columbus has been elected a fellow of the American Academy of Pediatrics. Dr. Schley was among the 300 members voted into membership at the organization's meeting at New York in May.

"Evils of Socialized Medicine" was the subject of the talk given by HARVEY SIMPSON, Americus, at the city's Life Underwriters Association meeting held May 25, 1962.

Fourth District

J. W. CHAMBERS of LaGrange, was the guest speaker at a May meeting of the West Point Rotary Club. Dr. Chambers spoke on "Medical Care for the Aging."

Selected on May 17, 1962, as the new Chief of Medi-

cal Staff for Sylvan Grove Hospital, Butts County, was WRIGHT G. HICKS of Jackson.

Fifth District

WINSTON E. BURDINE, Atlanta, was awarded, in May, the Catholic War Veterans of the Year Award for his work on the President's People to People Committee. On June second Dr. Burdine traveled to the Catholic War Veterans Meeting in Baltimore, Maryland, where he received the award and served as keynote speaker for the meeting.

Sixth District

No news submitted.

Seventh District

EDWARD L. BOSWORTH, Rome, was installed in May at Savannah as the new President of the Georgia Society of Internal Medicine.

Two Rome physicians, SARA LIPPARD HOYT and JAMES T. MATHENY, were elected in May as fellows of the American Academy of Pediatrics at the organization's meeting held in New York.

Eighth District

Waycross physician, VILDA SHUMAN, was reappointed to the post of eastern Georgia state advisor on Women's activities of the National Foundation-March of Dimes. The appointment was announced May 8, 1962, in New York.

Ninth District

No news submitted.

Tenth District

JOHN R. FAIR of Augusta, opened an office in May for the practice of ophthalmology. He is located at 1333 Harper Street, Augusta.

L. K. LEWIS, Madison, was elected in May as the treasurer of the Tenth District Heart Council.

Serving as the commencement speaker, June 2, for the Medical College of Georgia was EDGAR PUND of Seneca, South Carolina. Dr. Pund is a former president of the Medical College of Georgia at Augusta.

C. MARTIN RHODE, Associate Chief of Staff for Research, Veteran's Administration Hospital, Augusta, was honored in May by the Paralyzed Veterans of America. Dr. Rhode received a plaque and medal for devoted service.

V. P. SYDENSTRICKER, Augusta, was honored May 15, 1962, at the annual Sydenstricker Lecture. The lectures are supported by the student body of the Medical College of Georgia, where Dr. Sydenstricker is a Professor Emeritus.

At the recent annual meeting of the Heart Association's Northeast Georgia Chapter held in Athens in May, ADDISON W. SIMPSON, JR., Washington, retiring Chairman of the Board of Directors, was presented a Gold Meritorious Service medallion for service and leadership in the Heart Program since 1952.

MEDICAL ASSOCIATION OF GEORGIA COUNCIL MEETING

THE COUNCIL OF THE Medical Association of Georgia meeting was called to order at 6:35 P.M., by the Chairman George H. Alexander; he also gave the invocation.

The attendance was as follows: George H. Alexander, Forsyth; Fred H. Simonton, Chickamauga; Thomas W. Goodwin, Augusta; Milford B. Hatcher, Macon; Linton H. Bishop, Atlanta; Lee H. Battle, Rome; John T. Mauldin, Atlanta; John S. Atwater, Atlanta; J. Frank Walker, Atlanta; Charles Bohler, Brooklet; Frank Wilson, Leslie; Virgil Williams, Griffin; Floyd Sanders, Decatur; William Rawlings, Sandersville; Ralph W. Fowler, Marietta; F. F. Eldridge, Valdosta; C. R. Andrews, Canton; J. Frank McKemie, Albany; George Dillinger, Thomasville; Walter Brown, Savannah; C. T. Cowart, LaGrange; J. G. McDaniel, Atlanta; P. T. Scoggins, Commerce; M. A. Hubert, Athens; Eustace A. Allen, Atlanta; and J. W. Chambers, LaGrange. Staff members present were Mr. Milton D. Krueger, Mr. James M. Moffett, and Mrs. Catherine Wooten.

Review of Minutes

Mr. Krueger reviewed the minutes of the March 17-18, 1962, Council meeting. In the paragraph "Hamilton Letter" it was suggested that the wording be changed to read "Talmadge Hospital Liaison Committee" instead of Hospital Relations Sub-Committee. The minutes were then approved as read and corrected. The Executive Committee minutes of the April 30, 1962, meeting were read and approved as read.

Treasurer's Report

Dr. Atwater gave the treasurer's report. On motion (Hatcher-Fowler) it was voted to approve the report as submitted.

Atwater Commendation

Secretary Mauldin read a letter of commendation from AMA on John S. Atwater for his work on health care of aging. On motion (Mauldin-Hatcher) it was voted to refer this letter to the House of Delegates to be read by the Speaker as general information for the House.

Replacement of MAG Councilor Who Resigns

Secretary Mauldin gave Council information on the legal opinion regarding the resignation of a Councilor. According to the Bylaws it states that an appointment should be made to fill the vacancy created by the resignation. The District, whose Councilor has resigned, has already nominated a replacement, therefore, no action was necessary, as ruled by the Chair.

1962 Annual Session Review

Mr. Krueger reviewed the Councilor's schedule for the Annual Session.

Report on Workmen's Compensation Fees

Secretary Mauldin gave Council information regarding a proposed change in the Schedule of Fees of the State Board of Workmen's Compensation, and the call of a meeting on April 26, 1962, which he and Dr. T. A. Peterson, Chairman of the MAG Occupational Health Board, attended. On motion (Hatcher-McDaniel) it was voted to instruct the Secretary to keep in contact with the Board of Workmen's Compensation and when the fees are established to determine how members may obtain this information; also it was voted to publish the fee schedule in the *JMAG*.

Headquarters Office Report

Mr. Krueger asked Council to relay any information to the staff in the way of complaints, criticism, etc., concerning the Annual Session.

Unfinished Business

(a) Hamilton Letter: Chairman Alexander reported on the disposition of this problem. On motion duly made and seconded it was voted to pursue the matter no further and to instruct the Secretary to write the Governor regarding the details.

(b) Osteopathic Hospital Recognition: Chairman Alexander stated this problem was in the Legislative Board report and had been referred to a Reference Committee at this Annual Session.

(c) Spalding County Resolution: Secretary Mauldin stated that the AMA had been contacted regarding the introduction of this Resolution on Civil Defense problems before the AMA House of Delegates and it was the opinion of the AMA that there would be no objection.

(d) Gardner Letter: Secretary Mauldin read a letter expressing appreciation of Emerson Gardner's family for the expression of sympathy at the time of his death.

(e) Secretary Mauldin read a letter regarding Culver Kidd's statement on chiropractors.

(f) MAG Committee Appointments: Secretary Mauldin asked decision of Council on several appointments pending. It was recommended that this be done at the next Executive Committee meeting.

New Business

Dr. Goodwin discussed the following:

(a) A request for an Augusta physician to speak at the Michigan Osteopathic Association meeting was referred to Council for authorization or disapproval. It was recommended that Dr. Goodwin inform the physician that this would be referred to Council after the House of Delegates had made a decision on the osteopathy question.

(b) It was recommended that recognition of service be made to Mr. H. B. Collidge of the Savannah Blue Cross and Blue Shield Plan. On motion duly made and seconded it was voted to approve presentation of a Certificate of Appreciation for Mr. Collidge's work for the MAG Insurance and Economics Board and the presentation of a gift to him at the same time. It was recommended that Dr. David R. Thomas, Chairman of the MAG Insurance and Economics Board, make the presentation at the last General Business Session of the Annual Session.

(c) Lineback letter to Medical Economics was read. On motion duly made and seconded it was voted to refer this matter to the Fulton County Medical Society for action.

(d) Drs. Brown and Peterson extended an invitation to Council to attend a social hour and buffet supper at Dr. Brown's home after Council meeting.

(e) Dr. Dillinger announced his resignation from Council. Action on his resignation had been previously taken at this meeting.

(f) Chairman Alexander expressed appreciation to Council for cooperation during past year.

There being no further business the meeting was adjourned at 8:40 P.M.

1962-63 ORGANIZATION MEETING OF THE COUNCIL OF THE MEDICAL ASSOCIATION OF GEORGIA

THE 1962-63 ORGANIZATIONAL MEETING of the Council of the Medical Association of Georgia was called to order by President Thomas W. Goodwin, Augusta, at 11:50 A.M., May 9, 1962, in the DeSoto Ballroom, DeSoto Hotel, Savannah, Georgia.

Council members attending were: Thomas W. Goodwin, Augusta; John T. Mauldin, Atlanta; Fred H. Simonton, Chickamauga; Walter Brown, Savannah; George H. Alexander, Forsyth; Henry H. Tift, Macon; John S. Atwater, Atlanta; J. W. Chambers, LaGrange; C. T. Cowart, LaGrange; Lee H. Battle, Rome; Walker Curtis, College Park; H. D. Pinson, Augusta; William Rawlings, Sandersville; P. T. Scoggins, Commerce; T. A. Peterson, Savannah; George R. Dillinger, Thomasville; Charles Bohler, Brooklet; W. C. Mitchell, Smyrna; C. R. Andrews, Canton; Frank Wilson, Leslie; J. Frank Walker, Atlanta; Joseph B. Mercer, Brunswick; and Virgil Williams, Griffin. Mr. Richard Nelson, AMA Field Representative, was present, as well as staff members: Mr. Milton D. Krueger, and Mrs. Catherine Wooten.

Welcome to New Councilors

President Goodwin welcomed the new Councilors and Officers to the first Organizational Meeting of MAG Council for 1962-63.

Nomination and Election of Council Chairman and Vice Chairman for 1962-63

On motion (Bohler-Brown) it was voted to re-elect George H. Alexander, Forsyth, as Chairman of Council. On motion (Brown-Bohler) it was voted to re-elect Virgil Williams, Griffin, as Vice Chairman of Council.

Chairman Alexander thanked Council for re-electing him to this position and proceeded with the business at hand.

Council Appointment of Editor, *JMAG*

On motion duly made and seconded it was voted to reappoint Edgar Woody, Jr., Atlanta, as Editor of the *JMAG*.

Appointment of Council Finance Committee

J. G. McDaniel, Atlanta, was reappointed Chairman of the Finance Committee, with Virgil Williams, Griffin, and C. R. Andrews, Canton, as members of this committee.

Chairman Alexander then asked for a five-minute recess of the Council meeting in order for the Executive Committee to meet.

EXECUTIVE COMMITTEE OF COUNCIL ORGANIZATIONAL MEETING

THE CHAIRMAN OF THE Executive Committee of Council, Thomas W. Goodwin, President, called the Executive Committee to order at 12:00 NOON, in the DeSoto Ballroom, DeSoto Hotel, Savannah, Georgia, May 9, 1962.

Members of the Executive Committee present were: Thomas W. Goodwin, Augusta; Fred H. Simonton, Chickamauga; George H. Alexander, Forsyth; John T. Mauldin, Atlanta; Lee H. Battle, Rome; and John S. Atwater, Atlanta. Staff member present was Mrs. Catherine Wooten.

Appointment of Treasurer for 1962-63

By general agreement it was recommended that John S. Atwater, Atlanta, be reappointed Association Treasurer for 1962-63.

Selection of Executive Secretary for 1962-63

By general agreement it was recommended that Mr. Milton D. Krueger be reappointed Executive Secretary of the Medical Association of Georgia for 1962-63.

Date and Site of June Executive Committee of Council Meeting

By general agreement it was recommended that the Executive Committee meet at the same time as Council meets in June.

Appointment to Governor's Commission on Aging

The following three names are to be submitted to the Governor and he is to select one for his new Commission on Aging: Fred H. Simonton, John T. Mauldin and John S. Atwater.

There being no further business the Executive Committee meeting was adjourned at 12:05 P.M.

RECONVENED ORGANIZATIONAL MEETING OF COUNCIL

CHAIRMAN ALEXANDER CALLED THE reconvened organizational

meeting of Council to order at 12:06 P.M., May 9, 1962, in the DeSoto Ballroom, DeSoto Hotel, Savannah, Georgia.

Council Action on Executive Committee Recommendations

On motion duly made and seconded the previous action of the Executive Committee on the reappointment of John S. Atwater, Atlanta, as Treasurer for 1962-63 and the selection of the Executive Secretary, Mr. Milton D. Krueger, was approved.

New Business

Chairman Alexander thanked the Georgia Medical Society Councilors in behalf of the Medical Association of Georgia Council for the social hour and dinner.

Date and site of June Council meeting: President Goodwin extended an invitation from Richmond County Councilors to Council to meet in Augusta, June 16-17, 1962. On motion (Bohler-McDaniel) it was voted to accept this invitation.

There being no further business the meeting was adjourned at 12:10 P.M.

SPECIAL CALLED MEETING OF EXECUTIVE COMMITTEE OF COUNCIL

A SPECIAL CALLED TELEPHONE conference meeting of the Executive Committee of Council was held May 21, 1962. Those present on the conference call were Thomas W. Goodwin, Augusta; Fred H. Simonton, Chickamauga; George R. Dillinger, Thomasville; J. G. McDaniel, Atlanta; George H. Alexander, Forsyth; Lee H. Battle, Rome; and John T. Mauldin, Atlanta. Staff members present on the call were Mr. M. D. Krueger and Mrs. Catherine Wooten.

The Conference call began at 4:09 P.M., with Secretary Mauldin, acting in his capacity as Medical Director of the MAA Program, stating that the State Welfare Department is releasing more money to further expand the Kerr-Mills Program on June 1, 1962. He suggested that the Executive Committee consider two 15-day hospital admissions, instead of the three 10-day admissions now in effect, as he felt it would serve the purpose of better treatment of the elderly patient, and he also recommended that patients be admitted for elective prostate and cataract surgery. On motion (McDaniel-Simonton) it was voted to accept the Medical Director's recommendations, as stated above.

On motion duly made and seconded it was voted to send a notice of the expansion of the Kerr-Mills program in Georgia to President Kennedy and Congressmen Mills, King, and Anderson.

There being no further business the conference telephone call meeting was adjourned at 4:15.

MARK THESE DATES ON YOUR CALENDAR

MAY 5-8, 1963

109th ANNUAL SESSION

of the

MEDICAL ASSOCIATION OF GEORGIA

Jekyll Island, Georgia



United States
of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 87th CONGRESS; SECOND SESSION

Vol. 108

WASHINGTON, TUESDAY, JULY 17, 1962

No. 121

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SEP 5 1962

San Francisco, 22

The Senate met at 12 o'clock meridian, and was called to order by the President pro tempore.

The Chaplain, Rev. F. Harris, D.D., offered prayer:

prayer:
O Thou who art the
out of the depths of our
passion do we call upon
children under other
who by the hands of
are being deprived of
are theirs by Thy decree
Thy will that they sh

Forbidden that in the exultant, triumphant, and uncoerced freedoms of the American people, the yearnings of the enslaved should fall on our ears and find no compassionate response because of the selfish revelry in our own God-given rights.

our own God-given rights.

At the beginning of each yearly week set aside by this free and sponsored by our national leaders would this day join in our supplications with those who pray from sea to sea, those whose sovereignty and culture and treasure traditions, whose identity self-determination, who down, are being the dust of servitude by the oppressors who hold not Thee in awe.

May the peoples now in chains not
lose heart, even as their cry in affliction,
"How long, O Lord, how long?" rises to
the white throne of Thy mercy.

In this week of remembrance, we would register a vow in heaven and on earth, Thy footstool, as we bow at the altar of Thy justice, that we will never, never deny our expectant faith in the ultimate freedom and welfare of the nations now overrun by invaders who seize the crown jewels of others to enrich their own den of thieves, and leave behind a crown of thorns. Thus we make our plight of all fettered peoples our own, as in this shrine of our patriotic devotion we pray, "Long may their land be bright with freedom's holy light," after the present dictators have had their brief and evil sway.

We ask in the name of the One whose blood makes men free, and who declared, "I am come to bring deliverance to the captives." Amen.

On request
anonymous co
al of t
13. 1962

MESSAGE
ROL

A message from the House representatives, reading: "The House Speaker had affixed his signature to the following enrolled bills, and they were signed by the President."

10595. An act to amend the law relating to the sale of stocks of extra

LEGISLATIVE CALEN-
PENSED WITH

Mr. HUMPHREY, and by
ent, the call of the Leg-
was dispensed with.

LIMIT RING

On request of Mr. HUMPHREY, and by unanimous consent, statements during the morning hour were ordered limited to 3 minutes.

~~EXECUTIVE COMMUNICATIONS~~

The PRESIDENT pro tempore laid before the Senate the following communications and letters, which were referred as indicated:

PROPOSED AMENDMENT
FOR THE DISTRICT
No. 108)

No. 106)
A communication from the President
of the United States, transmitting an amend-
ment to the budget for the fiscal year 1961
in the amount of \$42,000,000 for the District
of Columbia (in accordance with the District
of Columbia Appropriation Act, 1961, approved
October 3, 1960).

PLANS FOR
VARIOUS STATES AND

A letter from the Director
Budget, Executive Office

MACARTHUR AT WEST POINT, N.Y.

A letter from the Secretary of Defense expressing approval of the joint resolution passed by Congress, relating to the address delivered by Gen. Douglas MacArthur at the U.S. Military Academy, West Point, N.Y., on May 12, 1962, and outlining plans for further utilization of the address by the Armed Forces to the Committee on Armed Services

ACTIVITY OVER TRUST POWERS OF NATIONAL
BANKS

A letter from the Secretary of the Treasury, transmitting a draft of proposed legislation to place authority over the trust powers of national banks in the Comptroller of the Currency (with accompanying papers), to the Committee on Banking and Currency.

to the Committee on Banking and Currency

AMENDMENT OF SECTION 105 OF REVISED
STATUTES, RELATIVE TO CONVERSION OR
CONSOLIDATION OF BANK BRANCHES

A letter from the Secretary of the Treasury, transmitting a draft of proposed legislation to amend section 5153 of the Revised Statutes, relating to bank branches which may be retained upon conversion or consolidation or merger (with accompanying papers), to the Committee on Banking and Currency.

REPORT OF PACIFIC MARINE FISHERIES
COMMISSION

A letter from the Chairman, Pacific Marine Fisheries Commission, Portland, Oreg., transmitting, pursuant to law, a report of that Commission, for the year 1961 (with an accompanying report); to the Committee on

GRANTS TO NONPROFIT INSTITUTIONS AND ORGANIZATIONS FOR SUPPORT OF RESEARCH PROGRAMS

the Administrative Assistant
Interior, transmitting, pur-
a report on grants made to
stitutions and organizations for
scientific research programs, dur-
year 1961 (with an accompany-
to the Committee on Govern-

AMENDMENT TO LOAN UNDER SMALL RECL-
PROJECTS ACT OF 1956

PROJECTS ACT OF 1906
A letter from the Assistant Secretary of
the Interior transmitting, pursuant to law,

12679

R IS FOR RAGWEED... MOST TROUBLESOME ALLERGEN

R

...more or less continuous syncopation in the melody
...Colloq. A type of music (ragtime music) char-
acterized by a strongly accented accompaniment
posed upon a regularly accented accompaniment.
rag'weed' (-wed'), n. a Eng. The ragwort. b U. S.
Any of several coarse herbs (genus *Ambrosia*) typi-
fying a family (Ambrosiaceae, the ragweed family)
having heads of flowers subtended by an involucre
of bracts; esp. a very common weed (*A. elatior*)
with deeply lobed or dissected leaves; and the **great**,
or **giant**, ragweed (*A. trifida*), with trilobate leaves.
The cockleburs (see COCKLEBUR) also belong to this
family.
rag wort, (-wurt'), n. Any of several plants (genus
Senecio) of the aster family, as the **golden ragwort**
(*S. aureus*) of the United States, having an open
corymb of yellow-rayed flowers.
ra'ya, coll. sing. ra'iyah, flock, herd.] A non-Mos-
lem subject of the Ottoman Empire.
road, See ROAD raid, way.]
ra'ya, coll. sing. ra'iyah, flock, herd.] A non-Mos-
lem subject of the Ottoman Empire.
road, See ROAD raid, way.]
ra'ya, coll. sing. ra'iyah, flock, herd.] A non-Mos-
lem subject of the Ottoman Empire.
road, See ROAD raid, way.]





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Special Article

"A FIGHT FOR FREEDOM"

LEONARD W. LARSON, M.D.

Past-President, American Medical Association

THE AMERICAN MEDICAL ASSOCIATION is emerging from a great struggle, opposing the most massive concentration of power ever brought to bear against the medical profession. We have fought a formidable alliance of government and labor. The executive branch of the federal government, using federal employees and taxpayers' funds controlled by President Kennedy, and the AFL-CIO, utilizing the far-flung empire of money and manpower commended by its national leadership, have combined their enormous strength against us.

I have been asked on occasion why we have engaged ourselves, our time and energies and resources to such unequal combat, why we submit to the vilification and abuse that has been heaped upon us week after week for months on end, why we undertook this battle at all. My reply is that to understand our reasons you must look to the deeper meaning of this struggle. This is not merely a quarrel over the provisions of a piece of legislation known as the King-Anderson Bill. This is not simply an argument over whether government should tax one group of citizens to provide health benefits indiscriminately, regardless of need, to another group. This is not solely a disagreement over the best means of providing health care for our elderly citizens.

No, this conflict touches on issues more grave, more important to the American people. This great struggle has been testing again whether the science and art of medicine will be permitted to grow and flourish in freedom, or whether progress in medicine will be stunted and shriveled by the excesses of government control.

Last fall when I spoke to this House of Delegates, I quoted from a speech of Senator Robert Kerr. It

was appropriate then and it is appropriate now as an evaluation of the purpose for which we have fought so hard.

"I would not discourage you," Senator Kerr said, "because the task is not hopeless—but it's not self-executed. You have probably the greatest opportunity of any generation of your profession that has ever lived, and all future generations of your profession are going to know whether or not you did your part in keeping the environment for them that has been such a blessing to you. If you do what you are capable of doing and the rank and file of those identified with you across the nation join you, you can tell your children that you made the fight that kept for you the environment which has been your blessing—and passed it on, unimpaired and unsullied, to those that you love even more than you do yourself."

Many others have recognized the deeper meaning of this conflict. There is the 12-year-old boy who wrote, pleading with us not to waver in our determination to win because he wants to be a doctor but not under socialized medicine. There is the woman concerned for the future of her children. "It is because of these children we are aiding and abetting your cause," she wrote. "Their freedom is at stake as much as your profession, and it's all disguised in a pretty little package where the government provides everything for its people—including the time of day if it were possible." There is the man who voiced his recognition of the fundamental issue involved in these words: "The doctors of our country can do wonders to save the lives of our people, in more ways than one." Others have been equally perceptive—and grateful. Without the AMA, one said, "How could those of us who subscribe to less government, more individual responsibility have stood up under the President's hurricane?" And another wrote a

Addressed to the House of Delegates at the 111th Annual Meeting of the AMA, Chicago, Illinois, June 25th, 1962.

thank you from the grass roots "for the job the AMA is doing—not so much in its own behalf as for all Americans."

Why do we fight? These people, and thousands more like them, answer this question for us in words more eloquent than any I can command.

Their letters are among more than 41,000 pieces of mail we have received since our television program May 21. More than 90 per cent of the letters support our position and our cause.

These letters of gratitude and encouragement came from people of all ages, the very young and the very old, and of all walks of life. Coming from all corners of the country, they signify a widespread and growing understanding that we are fighting to safeguard for the people themselves a progressive and dynamic system of medicine without equal anywhere on earth. They signify a widespread and growing belief that if the freedom of medicine is lost, other freedoms are in jeopardy.

A Symbol

But they are a symbol of something else to me—the fact that physicians everywhere have acquitted themselves proudly in this arduous campaign. Physicians have responded to the strenuous demands upon their time and energies and talents with patience and good taste, with courage and honor. They have met abuse and slander with forbearance. They have answered misrepresentation and deception with truth and fact. The results have won the respect and admiration of our friends as well as our critics, and they have confounded our enemies.

Six months ago, our critics were writing us off, predicting that we could not avert defeat. The alliance of government and labor had mounted the most gigantic lobbying offensive in the nation's history. Officials and employees of the federal government by the scores were dispatched on barnstorming tours across the country at taxpayers' expense openly lobbying for the King-Anderson scheme. This army of itinerant salesmen for this proposal were sent out without regard to whether such use of government personnel and tax funds is improper and might also be a violation of law. A suite in the White House Office was opened up and manned by a staff directed to grind out speeches, news releases, advertising copy, articles for magazines and newspapers, radio and television scripts and other propaganda for King-Anderson. An organization of senior citizens was formed for the exclusive purpose of lobbying for the King-Anderson Bill. This organization is lobbying, but it has ignored the law which required that it be

registered as a lobbyist and account for the source of its funds and how they are spent. The leadership of this council of senior citizens quickly converted it into a political tool of the Administration and the AFL-CIO. The executive director of the council acknowledged in a magazine interview that the White House was "calling the shots" for its pro-King-Anderson campaign. The council was billed as the sponsor of the May 20 King-Anderson rallies around the country, but in city after city, officials of labor unions were identified as the rally organizers.

The Odds

Against the tremendous power of this government-labor combine, I am sure the AMA was expected to buckle and retreat in panic and confusion. I am proud to say we did not. Instead, we doubled and redoubled our efforts, never wavering in our belief that we would win this greatest struggle in the history of the AMA. As I stand here before you today, I am more firmly than ever convinced that we will win the battle and the war. A tidal wave of genuine grass roots opposition to the King-Anderson Bill has produced a flood of letters to Congress demanding that it reject the bill. Even our severest critics now concede that only by a miracle can the bill survive a vote in the House Ways and Means Committee. Administration sponsors are frantically seeking what is described as a compromise in a desperate eleventh hour bid to stave off defeat. The odds are running in our favor.

No Compromise

Let me say a word here about compromise. The steadfast refusal of the AMA to compromise on basic principles, even in our darkest hours, has been a source of strength for us and our friends. We have taken an adamant stand against proposals that would lead to the centralized, government control of the practice of medicine in whatever guise they have been offered. If we begin now to bargain away that principle, we will sap our strength, splinter our forces and create a pattern for surrender. Furthermore, we have no need to compromise on the King-Anderson Bill. We are on sound ground and always have been. We are *for* the expansion of voluntary health insurance and the prepayment plans for the solvent and self-reliant, and *for* the Kerr-Mills Law to help those who need help. The Kerr-Mills Law may not be a perfect instrument for the task of providing financial assistance to the needy aged for medical care. It may require adjustment to make it more effective. But it is sound in principle. What it needs most is administrators—federal and state—who are dedicated to its success, not its sabotage.

Our beliefs in these and other areas are constructive and affirmative. We are *for* improvement in the public attitude toward our older citizens. We are *for* flexible, voluntary retirement programs in industry and government so that the productive capacity of older employees will be used for their benefit and the benefit of the nation. We are *for* the preservation of the right of our citizens to make their own decisions in a free society. We are *for* voluntarism and against compulsion.

Obligation

While I am confident of victory in this struggle from which we are emerging, I am mindful that victory will carry with it a solemn obligation for all members of this House and all physicians they represent—the obligation of responsible leadership. Ten years ago, a survey disclosed that half the people in this country had never heard of the American Medical Association. Today, I am certain that virtually every adult at least has some knowledge, however meager, of the AMA. Because we have conducted our campaign honestly and vigorously and because we are close to achieving victory against heavy odds, the stature of the AMA and all of its members has been enhanced materially. Consequently, the physician can anticipate that he will be called upon to assume a role in society that heretofore he may have shunned for a variety of reasons. That role will be leadership in community, state and national affairs. It is incumbent on each of us to accept the responsibilities of leadership, not as a burdensome duty but as an obligation of mature men. Let me add that the actions of this House this week and in the future should reflect your awareness of your obligation to exercise responsible leadership.

Civic Participation

Medicine is an institution of service to mankind. Public attitude toward the medical profession reflects to a significant degree the manner in which the individual physician serves his patients. Much criticism of the profession is unjustified, some is not. Much of it is based on misinformation and misunderstanding. I am convinced that greater involvement by the physician in community affairs will help immeasurably to smooth out the two-way avenue of understanding between the physician and his patients and help create a climate in this country which will make it unlikely, if not impossible, that a new King-Anderson type measure will be proposed again.

Before I leave this platform, I want to make it clear that I do not entertain any notion that the American Medical Association has stood alone in

this battle. On the contrary, we have been aided by a host of friends dedicated to the same principles that we are. Their tireless and effective work has made our task vastly less difficult. Among our magnificent allies may be counted millions of individual citizens who are as steadfastly opposed to government controlled medicine as we are. Many great national organizations have unhesitatingly taken on their full share of the burden of this struggle—the American Farm Bureau Federation the health insurance and pharmaceutical industries, the Blue Shield Plans, the U. S. Chamber of Commerce and local chambers, the Federation of Business and Professional Women, national and local junior chambers of commerce, the American Dental Association, Young Americans for Freedom—and many others. My gratitude and thanks to all of them are boundless.

Kudos

I want to take this opportunity also to congratulate the staff of the AMA, particularly the staff task force, the officers and executives of state and county medical societies and the thousands of physicians who are their members, and the women of the auxiliaries for a truly extraordinary performance in medicine's most critical hour. It is particularly fitting and appropriate that the presidents of our 52 state and territorial societies are in attendance at this meeting and will be on stage when Dr. Fister is inaugurated as the 116th president of the AMA.

Further Political Activity

If victory is close, it is because thousands of people—physicians, staff members and women of the auxiliaries—have worked together in a tremendous demonstration of effective team-work. Let me caution you, however, that if the battle is ours, the basic philosophical conflict remains. We cannot afford the luxury of idleness or complacency. It is imperative that physicians, their wives and other adult members of their families become active in politics to a degree they never have before. I urge all physicians and their families to support AMPAC and to engage in political activity in their communities, their counties and their states. If they devote as much energy to politics as they have to the King-Anderson fight, I am certain they can exert a strong influence on the course of elections next fall. Success at the polls in congressional elections next November and in future elections—is the key to the preservation of the freedom of medicine.

At this time, I want to make certain observations—at least for the record—which reflect my growing concern over actions and situations which I believe do not improve the efficiency of our association. If we are to carry out effectively the responsibilities

that historical events are demanding of us, our organizational efficiency must be maintained at an optimum level.

Fortunately, a man who is about to become a past president can have the temerity to discuss questions which are inherently sensitive politically. I am referring to the relations between the Board of Trustees and the House of Delegates and between Committees of the House and the Board. I think the House must appreciate that the Board of Trustees, selected by this House from the membership of the House is, in effect, the Executive Committee of this House of Delegates. Enormous responsibilities are vested by the Constitution and Bylaws in this Committee of the House, which is called the Board of Trustees. I need not tabulate them, for most of you are aware of them. But I believe that you are, perhaps unwittingly, undermining the effectiveness of the Board and therefore of the Association as a whole, by continuing to appoint committees of the House of Delegates for the study of problems and the conduct of programs that traditionally have been the responsibility of the Board of Trustees or a committee answering to the Board. I do not question your right as the House of Delegates, as the policy making body of the AMA, to disperse important decision-making among many different committees, but this effort to assure internal checks and balances can go so far as to achieve only splintering, needless overlapping and organizational confusion. I urge you to consider again the logic of the existing relationship between certain standing committees of the House of Delegates to the House, as well as the establishment of several recent continuing committees which also report directly to the House.

I should like to call your attention to a Bylaws provision under Chapter X, Section III, Page 21, which was adopted some years ago in an effort to

establish a clearer authority and responsibility for the Board of Trustees. The key sentence of Section III, under Chapter X, "Committees of the House of Delegates," reads "Committees that function during the interval between sessions of the House shall be under the direction of the Board of Trustees." The action of the then House of Delegates which led to this important provision has been honored more in the breach than the observance thereof. A strong reiteration of this provision of Section III by this House of Delegates would go far toward reversing recent trends which I believe are incompatible with the optimum development of our organizational needs.

This is my farewell address to this House of Delegates. In a few hours, I will step down as your president and turn the reins over to my able successor, Dr. Fister. Mere words cannot express my feelings at this moment. I am profoundly grateful to all of you for having given me the privilege and the honor of serving as your president, and particularly for having entrusted this office to me at such a critical time in our history. While I retire as your president, I assure you I will not cease my interest in the problems and programs of the AMA. I hope that I will be able to serve the association in other capacities in the future as I have in the past.

I want to express my gratitude to Dr. Hussey and the other members of the board, to Dr. Blasingame and Dr. Howard and other members of the staff for the generous assistance, unstinting cooperation and wise counsel they have given me during the past year. My thanks goes also to the many members of this House—too many to list here by name—who have given me support and assistance in the administration of this office. The unfailing help and cooperation of all of these people have made my tasks infinitely easier.

Again, my thanks—to all of you.

FILMS AVAILABLE ON ESTROGEN THERAPY

As the scope of estrogen therapy enlarges and the use of estrogens increases, knowledge in this area similarly grows. Current opinions—on estrogen therapy in specific conditions—are available now in the form of three new films:

1. *Atherosclerosis and the Role of Estrogens*, reporting on the ability of estrogens to increase the survival rate in patients with myocardial infarction.
2. *Hemostasis and the Effect of Estrogens*, reporting on the mode of action and the clinical effectiveness of estrogens in controlling hemorrhage.

3. *The Menopause and the Role of Estrogens*, reporting on the use of estrogens in the management of certain postmenopausal states or sequelae—with specific reference to lack of carcinogenic effect.

The films are the result of round table conferences directed and supervised by the Excerpta Medica Foundation in which outstanding authorities participated.

Each of the round table discussions is a 16 mm., black and white, sound film taking 30 minutes. Ayerst Laboratories will loan them without charge to any interested medical group.

THE CURRENT STATUS OF VENOUS SHUNTS IN PORTAL HYPERTENSION DUE TO HEPATIC CIRRHOSIS

Erwin R. Jennings, M.D., and Benjamin A. Addison, M.D., *Brunswick*

■ *Hemorrhage from esophageal varices is an ominous complication of portal hypertension.*

IT IS ESTIMATED THAT 50 per cent to 80 per cent of patients with portal hypertension due to hepatic cirrhosis die within one year after their first bleeding episode.

Portal systemic shunts appear to be the most effective treatment available to control hemorrhage due to portal hypertension. Hallenbeck,⁷ Dye,² Welch,³ and others have reported extensive experience in support of these procedures. Operative mortality may be as low as seven per cent in some series, and recurrence of hemorrhage varies from 4.5 per cent to 40 per cent depending on the technique employed. The rationale for such surgery seems justified when one compares these figures with the impending mortality without shunts.

Indications

Hemorrhage from esophageal varices is the primary indication for doing portal systemic shunts. Welch,³ also advocates shunt procedures in proven cases of esophageal varices without hemorrhage and in cases of hypersplenism treated by splenectomy. If manometric pressures in the portal system are found to be elevated at the time of splenectomy, consideration should be directed toward providing a venous shunt.

Relief of ascites, or degree of ascites, by venous shunt procedures is still controversial. In selected cases, definite relief of ascites has been obtained.

Despite these indications, operative intervention should be delayed until studies such as serum bilirubin,

B.S.P., Cephalin Flocculation prothrombin time, and serum albumin approach the values listed in Table 1.

Selection of Shunt Procedure

Technically, and in terms of effect, anastomosis of the splenic and left renal veins, and anastomosis of the portal vein to the inferior vena cava, remain the procedures of choice. Selection is in accordance with individual anatomical and disease patterns.

In considering the primary objective in venous shunt procedures, porto-caval anastomosis appears most effective in reduction of portal hypertension. An estimated 40 per cent more blood is carried by this anastomosis than by the spleno-renal union.⁴ However, in most instances of portal hypertension secondary to extra-hepatic block, porto-caval anastomosis is not technically feasible.

Portal hypertension with associated splenomegaly and hypersplenism is usually best treated by splenectomy and spleno-renal anastomosis, thus obviating the possibility of continued hypersplenism after portal decompression.

Prior to surgery, and after thorough evaluation of clinical variables such as spleen size, degree of hypersplenism, etc., a spleno-portogram is done. Contrast media is injected into the spleen outlining the portal venous system and/or possible site of portal block. In cases of previous splenectomy, the portogram may be done by injection of a portal system radical at operation.

Porto-caval shunts are usually performed unless other factors indicate the spleno-renal procedures as more feasible. If pre-shunt portal vein compression causes little or no rise in pressure, end-to-side porto-caval technique is employed. If pressure rise is over 100 mm water, a side-to-side technique is preferred.

TABLE I—CRITERIA FOR SURGERY

Serum Bilirubin	less than 3 mgm. %
B. S. P.	less than 20% retention
Cephalin Flocculation	2+ or less
Prothrombin Time	4 sec or less above control
Serum Albumin	3 gm. % or more

VENOUS SHUNTS / *Continued*

Surgical Technique — Illustrative Cases

Spleno-renal Shunt:

Spleno-renal shunt is usually done on patients with marked splenomegaly and demonstrably large splenic veins. A left thoraco-abdominal incision is made, and after exploration, manometric pressures are taken. Splenectomy then follows, taking care to preserve as much of the splenic vein as possible. It is frequently necessary to tie off some of the branches of the splenic vein as they emerge from the tail of the pancreas. The splenic vein is dissected, and the exposure carried to the left renal vein after incising the posterior parietal peritoneum. The renal vein is dissected free, then tangentially clamped by means of a blood vessel clamp in such manner as to occlude only the portion of the renal vein which will be utilized for anastomosis. An end-to-side anastomosis is completed between the end of the splenic vein and the side of the renal vein by any of the conventional methods. Manometric determinations of the portal system are taken utilizing an omental vein or gastroepiploic vein. Liver biopsy is obtained and the incision closed without abdominal drainage.

Illustrative Case

Case of Mrs. M. W. This 40-year-old white female was admitted to the Glynn-Brunswick Memorial Hospital on June 16, 1957, because of massive hematemesis and rectal bleeding. This patient had known hepatomegaly and massive splenomegaly during the preceding four years. After control of hemorrhage, work-up revealed esophageal varices, hepatomegaly, and moderate "hypersplenism." Supportive treatment was given. On July 3, 1957, a splenoportogram was done and a large portal vein was identified. A spleno-renal shunt was performed. A pre-shunt pressure of 340 mm water was recorded. Post-shunt pressure was 75 mm water. Liver biopsy confirmed portal cirrhosis. The patient completed an uneventful postoperative course and was discharged as improved on July 21, 1957.

Four years have passed without difficulty of any description.

Porto-Caval Shunt

Porto-caval shunts are usually performed in cases of intrahepatic block, secondary to cirrhosis of the liver. A right, thoraco-abdominal incision is usually made, though good exposure may be obtained through an abdominal incision. Abdominal exploration, liver biopsy, and portal pressures are taken. The free edge of the lesser omentum is incised. The portal triad is identified, and the common duct and hepatic artery are retracted. The hepatic flexure of

the colon is dissected and retracted caudally. The duodenum is mobilized by the Kocher maneuver. The portal vein is dissected from the region of the head of the pancreas to the hilum of the liver. The inferior vena cava is then mobilized from the level of the left renal vein to the liver. Care is taken only to mobilize the anterior and medial aspects of the inferior vena cava, otherwise, troublesome bleeding may be encountered from rupture of adrenal veins on the right lateral aspect. The portal vein is then dissected. Two small veins frequently enter the caudate lobe of the liver. These are ligated and divided. A non-crushing blood vessel clamp is then placed across the portal vein adjacent to the head of the pancreas. Portal pressures are again taken to determine the type of shunt. A marked pressure rise determines the side-to-side anastomosis. Otherwise, an end-to-side procedure is done. The portal vein is doubly ligated and divided close to the porta hepatis. If the vein is angulated at the pancreatic region, it may be necessary to remove a wedge of the pancreas to correct the angulation. No branches of the portal vein are usually encountered here, so this can be done with relative safety.⁵ A tangential, partial, occluding clamp is then placed on the anterior medial aspect of the inferior vena cava, and an anastomosis performed between the end of the portal vein and the vena cava. Manometric pressures are again recorded in the portal system. A pressure below 200 mms of water is desirable.

Illustrative Case

Case of Mrs. W. M. This 53-year-old white female was admitted to the Glynn-Brunswick Memorial Hospital on July 11, 1957, because of recurrent episodes of gastrointestinal bleeding. Previous work-ups revealed classical findings of portal cirrhosis with esophageal varices. The spleen was moderately enlarged, but there was no clinical evidence of "hypersplenism." On July 18, 1957, a splenaportogram was done, and a large portal vein was identified. An end-to-side porto caval shunt was performed through a right thoraco-abdominal incision. Initial pressure was recorded at 280 mm water. Post-shunt pressure was 180 mm water. Liver biopsy was confirmatory of portal cirrhosis. The patient completed an uneventful postoperative course and was discharged on August 3, 1957.

Follow-up over four years revealed the patient to be in good general health with no further difficulty.

Results

Mortality of venous shunt procedures in portal hypertension is reported from five per cent to 25 per cent. Operative mortality has decreased since criteria for operation have been set forth. Child⁷ reports a

series of no bleeding among 48 patients from one month to four years after direct porto-caval anastomosis.

Recurrent bleeding after spleno-renal shunts in experiences of Linton,⁸ Blakemore,⁹ Jahnke,¹⁰ Dye and Welch,³ varied from 12 per cent to 40 per cent. After porto-caval anastomosis by the same authors, recurrent bleeding was noted in 4.5 per cent to 36 per cent. (Table 2)

TABLE II—RESULTS FOLLOWING VENOUS SHUNTS

Authors	Mortality	Recurrent Bleeding	
		Porto-caval	Splenorenal
Welch & Ramos (13)	15%	5%	40%
Dye (2)	21.7%	36%	21%
Hallenbeck (1)	13.1%	21.7%	23.5%
Linton (11)	12.5%	11%	14.7%
Blakemore (9)	14.4%	6.6%	12.5%
Jahnke (10)	6.7%	4.5%	20%
Perkin (13)	19.2%	7.4%	30%

Summary

Since an estimated 50 per cent to 80 per cent of patients with hepatic cirrhosis die within one year after the initial esophageal varices hemorrhage, and reported series by various authors performing venous shunt procedures indicate a significant reduction in mortality and postoperative variceal bleeding, we may conclude venous shunt procedures are valuable and justifiable techniques in the treatment of portal hypertension.

Porto-caval shunts are the most effective techniques for the reduction of portal hypertension.

Close attention to preoperative criteria and preparation should result in successful control of portal

hypertension and coincident prevention of recurrent esophageal varices hemorrhage.

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GEORGIA HEART ASSOCIATION ANNOUNCES AID FOR RESEARCH

Four Georgia scientists are among the 400 investigators selected to receive support from the American Heart Association beginning July 1, according to Dr. Clarence C. Butler of Columbus, President of the Georgia Heart Association.

The newly announced awards are part of a \$10,000,-000 research effort that is being underwritten by the American Heart Association and its affiliates for the fiscal year 1962-63, Dr. Butler said. This research is supported entirely by public contributions to the annual Heart Fund.

Awards made in Georgia by the American Heart Association include the following: Gerhard A. Brecher, M.D., Influence of Partial and Complete Bypass on Capillary Circulation; Leon I. Goldberg, Use of Symptomimetic Amines in Congestive Heart Failure; John W. Manning, Central Integration of Cardiovascular Activity; all of Emory University School of Medicine; and

Wayne V. Greenberg, Mechanism of Estrogen-Induced Changes in Blood Lipids, of the Medical College of Georgia in Augusta.

Dr. Butler noted that these awards by the American Heart Association do not include projects supported directly by the Georgia Heart Association, announcement of which will be made shortly.

In announcing the national awards made in Georgia, Dr. Butler pointed out that this year the American Heart Association was able to support only 40 per cent of the grant-in-aid applications approved by its Research Committee. "Each of the studies for which funds were not available represents an opportunity lost," Dr. Butler said.

He expressed gratification, however, that all of the awards approved for Georgia institutions had received funds during the current year.

STRANGULATED FEMORAL HERNIA IN CHILDREN

Stephen W. Gray, Ph.D., and John E. Skandalakis, M.D., F.A.C.S., *Atlanta*

■ *A case of strangulated femoral hernia in a six weeks old child is presented and the literature is reviewed.*

This is the eighth case in a child under age ten in the literature and is the third youngest patient recorded.

STRANGULATED FEMORAL HERNIA in childhood is an unusual clinical entity. We have been able to find only eight cases in patients under ten years of age. Four were less than one year old. To these we wish to add the fifth case which will be the third youngest reported (See Table I).

Case Report

A 40-day-old female infant was admitted to the private surgical clinic Agioi Pantes, Athens, Greece, with a working diagnosis of right strangulated femoral hernia. The mother stated that six hours prior to admission the child vomited and started to cry. She cried constantly and vomited four times in the first three hours. When changing the diaper for a normal bowel movement, the mother noted a tumor "which was not there before," on the upper part of the right thigh close to the groin. The family physician (Mr. Kivelos) diagnosed a strangulated hernia and advised emergency hospitalization.

Physical examination revealed a healthy infant, well developed, but acutely ill. Delivery had been normal and previous history was negative. The child cried constantly and vomited twice during examination. The abdomen was soft with questionable distention

and hyperactive peristalsis. In the right groin, below the ligament of Poupart, below and lateral to the pubic spine, was a tender mass 4 cm in diameter. The overlying skin was discolored. Gentle attempts at reduction were unsuccessful and the child was taken to the operating room with a diagnosis of right strangulated femoral hernia.

Under a general ether anesthesia, the right groin was explored by a subinguinal approach, and a typical femoral hernia sac was found. The neck was medial to the femoral vein, lateral to Gimbernat's ligament, anterior to the pubis and posterior to Poupart's ligament. The sac contained a loop of small intestine together with the right ovary and tube. The intestinal loop was dark but regained its normal color as the neck of the sac was enlarged. The sac was ligated as high as possible with 0000 silk, and the femoral ring was closed by suturing Poupart's ligament to the pectineal fascia. The infant withstood the procedure well, and her post-operative course was uneventful.

Incidence of Femoral Hernia in Children

The chief argument against the congenital origin of femoral hernia has been its rarity in infants and

TABLE I—CASES OF STRANGULATED FEMORAL HERNIA IN INFANTS

Author		Sex	Age	Side	Contents of Sac	Onset
Cloquet ⁵	1878-9	F	Newborn	R	Ovary and Tube	-----
Harris ⁸	1893-4	F	5½ years	R	Ileum	3 years
Pillon ¹³	1898	F	21 months	R	Appendix, Ovary and Tube	19 months
Biasini ²	1936	F	6 years	R	Not Stated	6 weeks
Shepler & Smith ¹⁴	1940	F	69 days	L	Ovary and Tube	sudden
Innocenti ¹⁰	1946	F	2 months	R	Small Intestine	sudden
Underhill ¹⁷	1952	M	27 days	R	Small Intestine	sudden
Temple ¹⁶	1952	M	3 years, 9 months	R	Omentum	sudden
Present Case	1961	F	40 days	R	Ovary, Tube and Small Intestine	sudden

children. About 80 cases have been mentioned in the literature in addition to the strangulated cases listed in Table I. We have been able to find only three reports of femoral hernia in fetuses. The first two^{7,12} appeared in France over a century ago, within a few years of each other, and the third⁶ appeared in England fifty years later. All three fetuses were between two and three months of age. We have not seen any similar reports in the recent literature.

Frequency of pediatric cases has been variously reported from one, in 250 hernias in pediatric patients,⁹ to one in 167.⁴ Among 194 femoral hernias, Baum¹ found two in children. Thus, about four per cent of femoral hernia will be pediatric. In spite of the commonly stated influence of childbearing on the occurrence of femoral hernia in women, Mestel, Farber, and Chabon,¹¹ reviewing the literature in 1959, found even in the pediatric age group more than twice as many girls as boys with femoral hernia.

Figures for strangulation of hernias in children vary widely. Bucy³ reported that 13.2 per cent of all strangulated hernias at the Confederate Medical Center at Shreveport occurred in the pediatric age group but cited figures for another series of 3.4 per cent. Obviously the age distribution of patients in the two series is different.

Developmental Consideration

Weakness of structures around the femoral canal is not easily demonstrated in infants. Zimmerman and Anson¹⁸ have observed that the relative weakening of this region begins at the age of twenty. Various explanations have been put forward for the developmental formation of a femoral hernial sac:

- 1) Adherence of the developing femoral artery to the peritoneum pulls the latter into the femoral canal forming a peritoneal sac.
- 2) Abnormal attachment of fibres gubernaculum testis exert a pull upon the abdominal wall to form a peritoneal dimple, the precursor of a hernial sac.
- 3) Traction upon the peritoneum results from the adhesion of adipose tissue in the femoral canal with peritoneal fat in this region.

However attractive these theories, they remain possibilities without observational confirmation. Although empty femoral hernial sacs are known in adults, Tasche¹⁵ examined 64 newborn infants without finding one. While his sample was too small in view of the incidence of femoral hernia, the fact remains that a congenital predisposing defect has yet to be demonstrated.

That there is no proof of a developmental defect must not make us overlook the fact that femoral hernias do occur in children and that they may become strangulated. It should be noted that in at least one case¹⁷ the hernia was diagnosed as inguinal and the scrotum entered before the true condition was realized.

Emory University

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GROUND BROKEN FOR NEW OGLETHORPE MEDICAL CENTER

June 1, 1962, was the date of the groundbreaking for the new Oglethorpe Medical Center, located at Lexington, Georgia. An additional lot has been purchased by the Medical Center Corporation for possible future use. The James T. Rayle American Legion Post purchased and donated the one-half acre lot for the Medical

Center. The land will provide an area for parking 15 cars. When completed, the unit, designed to meet the needs of two doctors, will be among the most modern medical buildings of its size in the state. Funds were raised during the month of April and May with over 650 persons purchasing stock certificates.

THE TREATMENT OF PSEUDO-FOLLICULITIS

Vincent J. Cirincione, M.D., *Savannah*

■ *Significant improvement was noted following the use of barium sulfate depilatory powder.*

PSEUDO-FOLLICULITIS BARBE, a benign non-contagious dermatitis of the bearded area, is seen primarily in Negroes. The characteristic lesions are erythematous firm papules containing buried hairs. These papules are seen primarily along the mandibular areas and the undersurfaces of the neck and chin. Patients usually refer to them as "razor bumps." Subjective symptoms are usually absent; occasionally secondary infection and pustulization with tenderness and itching occurs.

The disease is notoriously chronic and resistant to the usual methods of treatment. Pinkus,¹ in a study of the disease, noted that the ingrowing hairs were the probable precipitating cause of the disease. Kligman and Strauss,² in a scholarly study of this condition, concurred with the above and observed that strongly curved hair which emerged only briefly almost parallel to the skin surface shortly re-entered the skin to form an ingrown hair. This curvature of the facial hair is a strong racial characteristic of the Negro. It was also noted by these authors that bacteria played no primary role in the pathogenesis of this disease.

It has been shown, and is a commonly known fact among patients with this disease, that allowing the beard to grow will clear up the disease in three to four weeks. Unfortunately, in an era when clean shaven faces are the fashion, this is impractical. It has further been shown that the frequency of shaving or the type of razor used has little effect on the disease.

Struck by the prevalence of this condition among adult Negro males, the writer of this paper decided to carry out a study, using a group of Negro college students suffering from Pseudo-Folliculitis Barbe. Treatment consisted of substituting a chemical depilatory containing barium sulfide* for whatever type of razor shaving the students had been using. The object of the study was two-fold: first, to de-

termine whether the use of such a depilatory would reduce or eliminate the "razor bumps" from which the students were suffering, and second, to determine whether any significant degree of skin irritation was caused by the depilatory itself.

Method of Study

Twenty-five students with the disease were chosen. The study extended over a seven week period and the candidates were examined and photographed at the beginning and at the second, fourth, and seventh week. At each session an attempt was made to evaluate the improvement clinically. The average age in the group was twenty-one, and all had suffered from "razor bumps" since beginning to shave.

Results

As was to be expected, there were several patients who failed to report for one or two examinations. However, there was no doubt that the use of the depilatory benefited a high percentage of the users so far as their Pseudo-Folliculitis was concerned. At the end of the first two weeks of using the depilatory powder, of 21 examined, 16 (76.2 per cent) were markedly improved, three (14.3 per cent) were improved, and two (9.5 per cent) were unimproved.

At the end of four weeks, 18 out of 21 reporting felt that their condition had improved.

At the end of seven weeks, 14 (82.3 per cent) of the 17 examined showed marked improvement (two or three papules, or none), two (11.8 per cent) showed improvement, and one (5.9 per cent) no improvement.

As for irritation, at the end of two weeks, 21 of those 24 reporting said they experienced no difficulty. Three had experienced some burning or soreness. Of these three, two continued using the powder at less frequent intervals. One dropped out, although examination showed no severe dermatitis.

At the end of the seven weeks, complete blood

*The barium sulfide depilatory used was MAGIC SHAVING POWDER supplied by the Carson Chemical Company.



Figure 1

Pseudo Folliculitis Barbe—before treatment.



Figure 2

Pseudo Folliculitis Barbe—after seven weeks of treatment.

counts and urine analyses were done on four of the patients. All were essentially normal.

On the positive side, therefore, the test showed that of the 25 patients, 23 showed improvement in varying degrees, one showed no improvement, and one ceased using the depilatory because it irritated his skin.

Summary

Pseudo-Folliculitis Barbe is a common disorder of the Negro male who shaves.

A barium sulfide depilatory powder was used in

treating twenty-five patients with this condition.

Satisfactory results were obtained in 23 out of the 25 cases treated over the seven weeks period.

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PRIZES OFFERED TO JR. AND SR. MEDICAL STUDENTS IN ESSAY COMPETITION

Junior and Senior students of all medical schools in this country have been invited to submit entries to "The Annual Walter Reed Memorial Essay Competition of The Brooklyn Hospital," according to Dr. Abraham G. White, Director of Medical Education. Three cash prizes will be offered: a one thousand dollar prize, a seven hundred and fifty dollar prize and a five hundred dollar prize. The closing date for entries for this year's competition will be March 1, 1963. Essays should be from 5,000 to 10,000 words in length and submitted in triplicate. The essay competition so named in honor of Dr. Walter Reed, a resident in The Brooklyn Hospital in 1872, will be an annual event. The prize-winning essays will be the property of The Brooklyn Hospital for suitable publication.

many present day educators believe sorely needs strengthening.

Emphasis should be placed on a clinical topic rather than one dealing primarily with the basic sciences. The student may use experimental data derived from personal researches, but there is no intent in any way to limit the subject material, which may fall within any branch of clinical medicine or surgery. Thus, an essay may be based on personal clinical observation of an unusual case or group of cases. Alternatively, the student may wish to review critically, problems of pathogenesis, diagnosis or the treatment of disease.

The committee of judges who will select the final winners comprises:

J. Arnold deVeer, M.D., Director of Laboratories, The Brooklyn Hospital.

John L. Dusseau, Vice President and Editor, W. B. Saunders Company.

Dickinson W. Richards, M.D., Professor Emeritus of Medicine, Columbia University College of Physicians and Surgeons.

Essays should be sent to:

Abraham G. White, M.D., Director of Medical Education, The Brooklyn Hospital, 121 DeKalb Avenue, Brooklyn 1, New York.

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THE CLINICAL APPEARANCE AND DIAGNOSIS OF PRIMARY MALIGNANCY OF THE PANCREAS

William Henry Lucas, Jr., M.D., *Rome*, and Victor A. Moore, M.D., *Augusta*

■ *Thirty-five cases of primary malignancy of the pancreas were reviewed in an attempt to correlate the clinical signs and symptoms, laboratory studies, and roentgenological procedures leading to their diagnosis.*

THE CASES PRESENTED WERE SEEN at the Eugene Talmadge Memorial Hospital on both the medical and surgical services from early 1957 until mid 1961 and were proven by histological examination of tissue obtained by laparotomy or at autopsy.

Symptoms and Signs

The cardinal symptoms and signs in this series, in descending order of frequency, were weight loss, abdominal pain, jaundice, hepatomegaly, anemia, an abdominal mass, nausea and/or vomiting, and abnormal glucose tolerance.

TABLE I—SYMPTOMS AND SIGNS

1. Weight Loss	33 (94.3%)
2. Abdominal pain	31 (88.6%)
3. Jaundice	28 (80%)
4. Hepatomegaly	26 (74.3%)
5. Anemia	18 (51.4%)
6. Abdominal mass	15 (42.8%)
7. Diabetes	12 (34.3%)
8. Nausea and/or vomiting	15 (42.8%)
9. Diarrhoea and/or steatorrhoea	3 (8.6%)
10. Thrombophlebitis	0 (0.0%)

Thirty-three patients (49 per cent) had marked weight loss which varied from the usual 20 to 40 pounds over a two to four month period, to one patient who lost 157 pounds in a year. Abdominal pain was present in 88 per cent of the patients. This pain was deep epigastric initially and usually radiated to the back. This symptom had been present two to four months as a rule. Jaundice was noted either by the patient or by the examiner on admission in 80 per cent of this series. This was the most frequent factor motivating the patient to seek medical aid. Because of this, the jaundice had been present only

a few days to a few weeks before admission. Hepatomegaly was found in 26 patients (74 per cent). None demonstrated marked hepatic enlargement, and no patient complained of a mass in the right upper quadrant. Eighteen patients appeared anemic to the examiner. A careful history elicited the symptom of progressive weakness, but this complaint had largely been secondary to a more prominent symptom. An abdominal mass, either a stony, hard tumor or rarely, a distended gall bladder, was palpated in 15 patients (43 per cent). The firm tumor was located in the mid epigastrium, while the distended gall bladder was in the right upper quadrant. Fourteen patients gave a history of nausea and vomiting and one had nausea alone. None of these complaints were due to intestinal obstruction. Twelve of the 35 had symptoms of diabetes; one of these twelve with marked weight loss and prolonged pain had been on diabetic treatment at least a year. These patients for the most part had no familial history of diabetes. Two other symptoms and signs frequently attributed to malignancy of the pancreas were noticeable by their scarcity or absence: three had diarrhoea (and of these only one had gross steatorrhoea), and none of these patients had a history or evidence of thrombophlebitis or thromboembolic phenomena.

Laboratory Studies

The laboratory studies producing the greatest yield of abnormal results were those concerned with obstructive jaundice (80 per cent) followed by tests showing deficiencies in hemoglobins and hematocrits (51 per cent). Next in order were tests demonstrating abnormal glucose utilization (34 per cent), stools positive for occult blood (28 per cent), and elevated

serum enzymes (SGOT and SGPT) (11 per cent). More specialized tests giving positive results, but done on fewer patients, were the secretin test, and hepatic and lymph node biopsies for histological study.

Obstructive jaundice was present in 28 patients, and in these cases there were hyperbilirubinemia, elevated serum alkaline phosphatase, and bilirubinuria. The serum leucine aminopeptidase was determined on only two occasions, both times in a jaundiced patient and was markedly elevated (200 and 280 units as compared to normal values of 20 to 85 units). In 18 patients there was a chronic blood loss anemia. This anemia generally was mild, but occasionally severe. Twelve patients had elevated fasting blood sugars, two hour post prandial blood sugars, and/or abnormal glucose tolerance tests. One patient's disease was so severe that he had been placed first on tolbutamide but later required insulin. Stools were positive for occult blood in ten patients. Probably this figure would have been higher had all the patients had frequent stool examinations. This assumption is based on the fact that 18 patients were anemic. The serum glutamic oxalacetic and glutamic pyruvic transaminase determinations were elevated in four patients. These patients had had prolonged jaundice. None of the values exceeded 300 units. The secretin test was done in only one case with decreased volume and amylase production after secretin administration. Three hepatic biopsies were done at surgery. Two revealed metastatic neoplasm while the third showed changes consistent with chronic biliary obstruction and secondary biliary cirrhosis. A lymph node biopsy was done on only one patient who had suspicious lymphadenopathy in the supraclavicular and axillary areas. The pathologist reported metastatic carcinoma in this biopsy specimen. Serum amylase and lipase determinations were no help diagnostically. Serum amylases were done in practically all the cases, and in only one patient with concurrent pancreatitis was there any abnormality. Serum lipase was measured only twice and was within normal limits both times.

Roentgenological Examinations

Abnormal roentgenological examinations were found in 15 patients (43 per cent). Ten had abnormal upper gastrointestinal series, two had abnormal gall bladder visualizations, one had an abnormal operative cholangiogram, one had an abnormal intravenous pyelogram, and one had an abnormal dorsal spine film. Practically all the patients had an upper gastrointestinal series and barium enema. A few had small bowel series in combination with the gastroduodenal studies. Only two had gall bladder series.

Nine of the upper gastrointestinal series revealed widened or distorted duodenal loops. One revealed a distorted barium filled stomach from an extrinsic mass impinging on the posterior wall. One patient without jaundice revealed dilation of the common duct on an oral cholecystogram. Another patient with receding jaundice failed to show visualization of the biliary tree on oral and intravenous cholecystography. A third patient with a palpable mass in the left upper quadrant demonstrated on intravenous pyelography a malpositioned left kidney caused by pressure from an extrinsic mass medial to the kidney. An operative cholangiogram performed on one patient with jaundice and an indurated area in the pancreatic head revealed obstruction of the common duct at the head of the pancreas. One jaundiced patient with severe back pain and a positive lymph node biopsy demonstrated on an x-ray film of the dorsal spine metastatic blastic lesions in the bodies of two vertebrae (D8 and D10).

TABLE II—LABORATORY AND X-RAY STUDIES

1. Positive tests for obstructive jaundice	28 (80%)
2. Abnormal x-rays	15 (42.8%)
3. Positive test for abnormal glucose utilization . .	12 (34.3%)
4. Positive stools for occult blood	10 (28.6%)
5. Elevated SGOT and SGPT	4 (11.4%)
6. Abnormal serum amylase	1 (2.8%)
7. Abnormal serum lipase	0 (done in 2)
8. Positive liver biopsy	(2 of 3)
9. Positive lymph node biopsy	(1 of 1)
10. SLAP elevation	(2 of 2)

Incidence Regarding Age, Sex, and Race

There were 18 Caucasian and 17 Negro patients in this series. Of the Caucasian patients, 14 were male and four female with a ratio of 3.5 males to one female. In the 17 Negro patients this sex ratio was almost reversed. There were 10 Negro females to seven Negro males giving a ratio of roughly 1.5 females to one male. These diseases occurred in middle and old age. There was one patient in the second decade of life, none in the third, three in the fourth, four in the fifth, nine in the sixth, nine in the seventh, seven in the eighth, and two in the ninth.

Types and Locations of the Tumours

Thirty of the primary malignancies proved on histological examination to be adenocarcinomas. Of these, 21 were in the head of the pancreas, four were in the body, four involved the whole gland, and one was confined to the tail of the organ. Of course, many of these had seeded metastases to the liver, regional nodes, peritoneum, and even more distant sites. Curiously, three patients with carcinoma of the pancreatic head were not jaundiced. Three tumours were identified as being anaplastic carcinomas. They were located in the head, body, and head and body

MALIGNANCY OF THE PANCREAS/Lucas

of the pancreas. One patient aged 20 had a carcinoid tumour thought on histological section to arise from the pancreatic head. This patient did not exhibit systemic carcinoid signs or complain of symptoms referable to this disease, but at laparotomy no hepatic metastases were seen. One patient had a primary sarcoma of the tail of the pancreas with hepatic metastases and jaundice.

Discussion

The clinical signs and symptoms, laboratory and roentgenological findings in these cases, correlate closely with those in Birnbaum and Kleeberg's¹ series, except for the racial difference in sexual susceptibility, absence of thromboembolic phenomena, and a much higher incidence of serum alkaline phosphatase elevations. The racial difference in sexual susceptibility might be explained that while their patients chiefly had semitic ancestry these patients' backgrounds were mainly Anglo-Saxon and Negro.

Mosely⁸ has recently reviewed the roentgenological procedures employed in the diagnosis of pancreatic tumours. These include gastroduodenal exams, operative pancreatography, pneumoretroperitoneal pancreatography, intravenous cholangiography, percutaneous direct cholangiography, and splenoportography. He also points out that the quest for a suitable dye selectively excreted by the pancreas which will give a good radiograph of the pancreas is as yet unfulfilled. Kaplan, et al⁶ have reported good visualization of the extrahepatic biliary tree in 40 patients, 30 with jaundice, by the technique of percutaneous transhepatic cholangiography. They had a surprisingly small number of complications, only four developed bile peritonitis necessitating surgery.

Even with the newer techniques for radiographic diagnosis of tumours in the pancreatic area, it would seem that still no satisfactory means have been advanced for early diagnosis. Patients with these tumours still require laparotomy for diagnosis. Therefore, radiographic study of the gastroduodenal area by means of upper GI series, with oral or intravenous cholecystography in non-jaundiced patients or in patients with receding jaundice, is adequate for pre-operative roentgenological work-ups. The most promising advancement in radiologic diagnosis in this condition would be the discovery of a dye selectively excreted by the pancreas in high enough concentration to give good opacification of this organ.

A useful procedure in the diagnosis of pancreatic disease is the secretin test.² Numerous combinations with this test have been used to diagnose cancer of the pancreas. The test will frequently show abnormal secretion of volume, bicarbonate, and amylase in the

presence of carcinoma of the head of the pancreas because of obstruction of the pancreatic ducts.³ When the malignancy involves the body or tail, there often is enough non-involved and non-obstructed tissue to produce normal volume, bicarbonate, and amylase in response to secretin stimulation.^{3,4} Also, in far advanced chronic pancreatitis there may be decreased production of all these elements.³ For these reasons Dreiling, Nieburgs, and Janowitz³ have combined cytological examinations for malignant cells in the sediment from the duodenal juice following secretin administration. In their hands, over 90 per cent of patients with carcinoma of the pancreas have shown abnormal secretin and/or cytological tests. Unfortunately, because of the necessity of an experienced pancreatic cytologist, this procedure must be reserved for large teaching or research institutions.

Sun and Shay⁹ failed to increase percentage yield of diagnoses by combining pancreozymin administration prior to administration of secretin and then measuring serum levels of amylase and lipase in addition to analysis of the duodenal juice. They got abnormal results in only one of five patients subsequently shown to have pancreatic malignancy.

It is well established that serum leucine aminopeptidase levels will be elevated in either intrahepatic or extrahepatic biliary obstruction and in metastatic disease to the liver.^{4,5} Therefore, this test is not of specific help in the diagnosis of pancreatic malignancy.

Malignancies of the pancreas with hormonal activity such as the insulin secreting islet cell adenocarcinoma and the non-insulin secreting adenocarcinoma with hypersecretion of gastric acid and atypical ulcerations puts them in a fairly easily recognizable category.

Summary

1. Thirty-five cases of primary malignancy of the pancreas seen at the Eugene Talmadge Memorial Hospital from early 1957 until mid 1961 were reviewed.
2. The most frequent clinical signs and symptoms in order of frequency were weight loss, abdominal pain, jaundice, hepatomegaly, anemia, abdominal masses, nausea and vomiting, and diabetes.
3. An interesting feature of this series indicated a 3.5 to 1 ratio of males to females in the Caucasian group, but a 1.5 to 1 ratio of females to males in the Negro group.
4. The most rewarding laboratory procedures were determinations of serum bilirubins, serum alkaline phosphatases, urinary bile, hemoglobins and hematocrits, fasting blood sugars, glucose tolerance tests, and stool exams for occult blood.

5. The most reliable reported clinical procedure prior to surgery is the secretin-cytology test, but this is not readily available.
6. Roentgenological studies which were most helpful were gastroduodenal exams by means of the upper gastrointestinal series.
7. Final diagnosis awaited histological examination of tissue obtained at laparotomy or at autopsy.

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TWO ATLANTA CHURCHES CO-OPERATE TO ESTABLISH APARTMENT-HOME FOR RETIRED

Two Atlanta churches are co-operating in establishing here a new kind of apartment-home for the retired—Canterbury Court. It will be built on a beautiful four-acre tract at 3750 Peachtree Road, N.W.

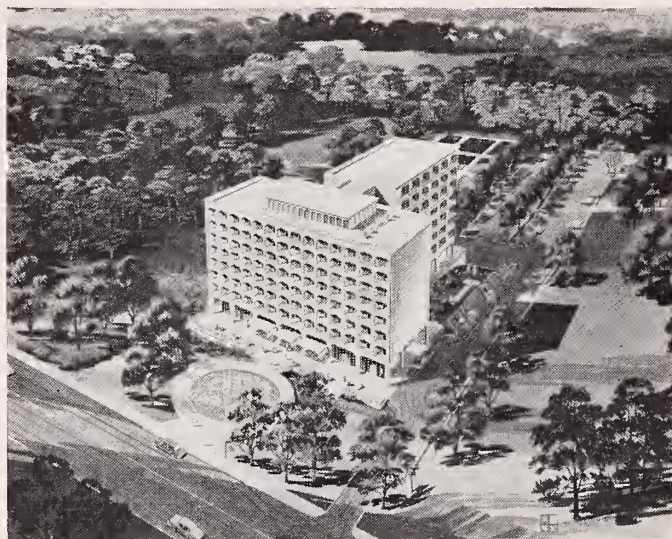
Architects are now working on plans for a handsome, eight-story, T-shaped building which will provide ideal living conditions for people over 62 years of age. It is expected to be ready for occupancy in the fall of 1963. Total cost will be about \$4,000,000.

Canterbury Court, a non-denominational, non-profit organization, will offer retired persons a new concept of living. Besides modern, attractive apartment units, its facilities will include a dining room where three meals will be served daily, a completely equipped infirmary staffed by nurses, a spacious main lobby, hobby centers, a sun deck atop the building, beauty and barber shops, and laundries.

There will be four main types of apartments—efficiency unit, and efficiency with kitchenette, a one-bedroom apartment and a two-bedroom apartment. A total of 198 apartments will be available. All of the units will have individual balconies, ample closet space, wall-to-wall carpeting, draperies, full baths and appliances in those with kitchens.

Two members of the Fulton County Medical Society, Dr. T. Sterling Claiborne and Dr. L. Minor Blackford, have been active in the organization of Canterbury Court. Dr. Claiborne is a member of the board of trustees. The apartment home will be owned and operated by the board. It will be under the direction of a full-time managerial staff.

Two types of fees will be charged residents. First is the Founders' Fee, which will be required for each apartment unit and guarantees a lifetime lease. These fees begin at \$8,600; they conceivably could be realized from equity in the home which the retired person no longer wishes to maintain. Residents also will pay monthly fees; these will cover the cost of daily meals, rent, linen service, air conditioning, lights, water, infirmary care and full use of the extensive facilities. Since Canterbury Court is a non-profit organization, the



CANTERBURY COURT Apartments for the Retired sponsored by All Saints' and St. Luke's Episcopal Churches of Atlanta. The eight-story building will contain 198 living units. The apartment will be constructed at 3750 Peachtree Road in Atlanta.

monthly fees will be based on actual costs. The board of trustees estimates they will range from \$140 a month for one person in an efficiency apartment to \$295 monthly for double occupancy in a two-bedroom apartment with kitchenette.

Besides its modern physical facilities, Canterbury Court will offer a cheerful atmosphere where retired people can live comfortably and graciously. They will have the companionship of congenial contemporaries.

Since 1900, life expectancy in this country has increased nearly one-third, largely because of advances in medicine and public health. By 1970 the number of persons over 65 will be almost 25 per cent greater than in 1960. Paradoxically, forced retirement ages are being lowered. Thus, increasing numbers of men and women are coming face to face with the problem of what to do upon retirement—particularly where to live. Canterbury Court will provide one answer to this challenge.

EXCESSIVE PENILE SKIN LOSS FROM CIRCUMCISION

John Van Duyn, M.D., and William S. Warr, M.D., *Columbus*

- ***A case is reported in which a cylindrical area of excess skin nearly a centimeter in length was inadvertently removed from the shaft of the penis.***

REPORTS OF MAJOR LOSSES OF PENILE SKIN as a complication of circumcision are fairly common; the causes of such loss being usually either a complicating infection,^{1,2} the use of the electrocautery,^{3,4} or improper surgical technic.^{5,6} Minor degrees of excessive skin loss appear to have attracted less attention in the literature,⁷ but we believe that they also are important for two reasons. One, is that considering the many circumcisions performed daily in this country by relatively inexperienced operators, these minor losses are perhaps, after all, quite common.

The other is that when these defects are allowed to heal without grafting, there may be "discomfort" during adulthood,⁸ and a shortening of the future functioning (erectile) length of the organ. Theoretically, even a minor inadequacy of penile skin in the shaft would tend to result in a holding back of the subcutaneous part of the penis against the abdominal wall.

An actual, if extreme, example of such a situation is found in a case reported by Byars in which so much excess skin had been removed at circumcision that contraction of the remaining skin almost completely "concealed" the penis.⁵ The subcutaneous part of the shaft was so crowded back against the fatty mons pubis that almost no organ projected. The opening in the contracted skin at the end of the penis barely permitted the escape of urine.

We have recently followed a case in which a minor excess of skin loss occurred during the routine circumcision of a newborn. We believe that although the length of the cylindrical skin loss in this case averaged less than a centimeter, replacement by a split skin graft was indicated. This decision and its carrying out resulted in a penis which is now normal in appearance and in which we anticipate a fully normal adult length and function.



Figure 1

Condition of penis three days after circumcision. The cylindrical defect measured 1 cm. in length inferiorly (on the left in the photograph) and 0.7 cm., superiorly (on the right in the photograph).

Case Report

B. K. A., white male, the result of a full term pregnancy, was born on 11/25/60. Birth weight was six pounds, ten and one quarter ounces. There was no difficulty with resuscitation of the child, and after delivery he was in good condition in the nursery. Physical examination revealed no abnormalities.

On the third day of life, 11/27/60, a circumcision was performed using a Gomco clamp and the infant returned to his bed with the result supposedly satisfactory. The next morning, however, the wound was found pulled apart, and it was apparent that an excess of penile skin had been inadvertently removed. Measurement of the cylindrical defect showed a gap of 1.0 cm. inferiorly and 0.7 cm. superiorly (see Fig. 1). On 11/28/60, the infant was transferred to the plastic surgical service and intermittent warm saline packs started.

Operation: On 11/30/60, under light general anesthesia, a split graft was cut from the left lower abdomen at 0.009 of an inch and wrapped around the defect in the penis. No sutures were used. The graft was covered with fine mesh gauze (Owen's rayon) and supported by a few turns of a narrow Gelocast bandage (Duke Laboratories, Inc.). Postoperatively, an effort was made to keep the infant on his side to avoid softening of the dressing with urine, and the hands and feet were restrained.

On the fourth postoperative day (12/4/60), all dressings were removed and left off, but restraints were continued for three more days. On the same day (12/4/60), a photograph was taken showing the graft had taken completely (see Fig. 2). Ten days after the operation (12/10/60), the patient was discharged from the hospital.

Follow-Up: On 2/15/61, two and one-half months postoperatively, the patient was seen in the outpatient department. There were no complaints from the mother. The graft was found to be normally loose and to have blended in nicely with the surrounding skin. There was no evidence of constricting scar tissue at the juncture lines (see Figs. 3 and 4).

Eleven months postoperatively a second follow-up visit was made, and the same satisfactory situation was found to exist. The mother was reminded that she should return with the child if any evidence of constricting bands should appear as the organ grew larger.

Discussion

While scrotal flaps are occasionally preferred for resurfacing the denuded penis, and especially where the injury involves the corpora cavernosa,^{3,9,10,11} and in one case an abdominal flap;¹² the treatment of choice is generally considered to be by means of a split graft, cut for adults at about 0.018 of an inch.^{1,4,13,14,15,16,17} Such a graft, when placed on Buck's fascia, contracts very little and appears to blend in rapidly with the surrounding skin.

Davis and Berner explain the success of split grafts on the penis as due to two factors: the frequent stretching of the grafts and the fact that the bed is loose fascia and not thick granulation tissue.¹⁵



Figure 2

Appearance of penis four days after splitgrafting. Graft was taken at 0.009 of an inch from the left lower abdomen.



Figure 3

Appearance of penis two and one-half months after splitgrafting. The graft resembles the surrounding skin and the suture lines can only barely be made out.

In the case of our infant the graft was cut at 0.009 of an inch and taken from the left lower quadrant of the abdomen. In this area the skin is hairless and the donor site can be closed by suture if desirable.

Although the eleven month follow up in our case revealed no evidence of tightness in the suture lines of the graft, it is still possible that as the penis increases in size such a complication might occur. If and when this should happen, the constricting bands could be dealt with by multiple Z-plastics, much in the manner of the treatment of congenital bands of the extremities.¹⁸

Summary

A case of routine circumcision in a newborn is reported in which a cylindrical area of excess skin measuring nearly a centimeter in length was inadvertently removed from the shaft of the penis. The defect was splitgrafted two days later with an apparently excellent result.

We believe that these minor excesses of skin loss following circumcision must be more common than indicated by the literature, and that many of them should be split grafted to avoid the possibility of a future scarred and/or shortened penile shaft.

102 Doctors Building

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Figure 4

Same as Figure 3, but showing skin pulled out inferiorly to demonstrate looseness. Note that there is no evidence of constriction at the juncture lines of the splitgraft and normal skin.

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Gubernatorial Candidates Outline Views On Health Matters*

MARVIN GRIFFIN

THE IMPORTANCE of state government to the health of the citizens of Georgia and the relationship of the state government to the medical profession are most important.

Enormous public interest has been stimulated in the question of medical care for the aged, although many other facets of state cooperation in health problems deserve serious appraisal and consideration.

In the form in which it was submitted to Congress, the King-Anderson Bill seems to me an unwise, ill-timed and injudicious experiment, approaching closely to socialization of the care for the sick and involving financial hazards to the reserves for retirement benefits and payments to widows and orphans. Whether a substitute will be devised cannot be foretold. At present, the Kerr-Mills Act is on the statute books. It has worked well in those states that have given it a fair trial and adequate support. It is not repugnant to any sensible view within the government or within the medical profession. It has been inadequately supported in Georgia. When I am elected governor, it will be adequately supported.

For my views in the general field of public health, I can only point to the accomplishments of the Griffin Years. The Department of Public Health was adequately financed. Substantial improvements were made at Milledgeville and Gracewood, and Battey was well supported.

I am convinced that we must do more in the field of mental health, and, subject to careful study by experts, I am inclined to believe that decentralized clinics, and small centers for cases needing and responding to rapid treatment, would be desirable.

In the field of care, treatment and training for retarded children, I am strongly of the opinion that treatment centers should be established at convenient locations about the state, instead of concentrated at the custodial institution at Gracewood. The progress of many of the children is affected by the ability of their parents to visit them frequently, and the establishment of a number of such centers is one of my objectives.

Good public health services and a good relationship between the state government and the medical profession is not only needed on humanitarian grounds but is an absolute requisite in developing a climate for economic progress in Georgia.

**On September 12th the people of Georgia will nominate a new Democratic Governor to serve the following four years. As the Chief Executive of Georgia he will exercise great influence in the maintenance of a working climate for the practice of medicine and in health matters generally. As a service to its readers the JMAG has solicited, from the two acknowledged "front runners" for the office of Governor, their views on medical matters. These views are presented herewith in full.*

CARL SANDERS

THE MOST PRECIOUS possession of the people of Georgia is their health. That statement will motivate all of my policies and programs in this field when I am privileged to serve as Governor of our healthy and healthful State.

My Legislative record, I think, best demonstrates my deep interest in the protection and preservation of the health of our people, and in the protection and support of the private practice of medicine . . . that noble profession you chose as your life's work.

I shall foster the continuing and all-important inter-linking activities of the Medical Association of Georgia, and State Department of Public Health.

I appreciate the understanding, assistance, and cooperation given by the Council and Committees of the Medical Association of Georgia to the State Health Department.

Your Association has been most helpful and effective in working with the Health Department's programs on general immunization, polio and cancer control, crippled children, heart disease control, and tuberculosis control and drastic reduction.

Nation-wide acclaim was justly accorded the physicians of the Fulton County Medical Society when they cooperated with the Public Health Department to give the Sabin polio vaccine to thousands of children and adults last year. This special project was credited with preventing an incipient polio epidemic of the paralytic type.

I am proud of having been the author of the Legislative Bill which set up the Medical Care Program for the 93,000 Georgians on old-age pension rolls. This program recently has been expanded, and I hope to expand it still further as the answer to the problem of meeting the medical care needs of senior citizens, whose experience, talents, and health we must conserve.

I have been especially interested and active in the State's new and model mental health program and intend to push it as rapidly as possible. The next target for my administration will be the opening of the projected nine-million dollar mental health center where all Georgians afflicted may come for intensive treatment which now is curing 90 per cent of those treated from four weeks to 56 days, thus making it unnecessary to endure the tragedy of living out their lives in Milledgeville. That was the mental health picture in Georgia just a few years ago.

I seek and welcome the support of the medical profession of Georgia . . . indeed will be honored to receive it. We can work together to make this one of the nation's healthiest states.

1962-63 CALENDAR OF MEETINGS

State

October 25-27—14th Annual Session of the Georgia Academy of General Practice, Atlanta Americana Motor Hotel, Atlanta.

October 31-Nov. 3—American Society of Tropical Medicine and Hygiene, Atlanta-Biltmore Hotel, Atlanta, Ga.

November 29-30—Fourth Annual Postgraduate Course in Ophthalmology of the Emory University School of Medicine, Grady Memorial Hospital, Atlanta.

Regional

September 6-8—American Association of Obstetricians and Gynecologists, The Homestead, Hot Springs, Virginia.

September 18-20—Kentucky State Medical Association, Brown Hotel, Louisville, Kentucky.

September 21-22—American College of Obstetricians and Gynecologists, District VII, Little Rock, Arkansas.

September 24-25—Tennessee Valley Medical Assembly, Chattanooga, Tennessee.

September 24-27—American Psychiatric Association, Mental Hospital Institute, Americana Hotel, Bal Harbour, Florida.

September 30-October 2—Fifth Annual Medical Progress Assembly, Birmingham, Alabama.

October 4-6—American College of Obstetricians and Gynecologists, District IV, Barringer Hotel, Charlotte, North Carolina.

October 14-17—Medical Society of Virginia, Sheraton-Park Hotel, Washington, D. C.

October 15-17—The Medical Society of the District of Columbia, Second Interstate Assembly with the Medical Society of Virginia, Sheraton-Park Hotel, Washington, D. C.

October 17-18—American College of Preventive Medicine, Inc., Hotel Fontainebleau, Miami Beach, Florida.

October 29-31—American Association for the Surgery of Trauma, The Homestead, Hot Springs, Virginia.

November 9-10—Southern Society for Pediatric Research, Gainesville, Florida.

November 12-14—Association of Military Surgeons, 69th Annual Meeting, Mayflower Hotel, Washington, D. C.

November 12-15—Southern Medical Association, Hotel Fontainebleau, Miami Beach, Florida.

November 14—Medical Society of the District of Columbia, Washington, D. C.

November 15-17—Southeastern States Cancer Seminar, George Washington Hotel, West Palm Beach, Florida.

National

August 26-27—American Academy of Physical Medicine and Rehabilitation, Hotel Commodore, New York City.

August 28-31—American Congress of Physical Medicine and Rehabilitation, Hotel Commodore, New York City.

August 30 - September 8—American Society of Clinical Pathologists, Palmer House, Chicago, Illinois.

September 1-4—College of American Pathologists, Palmer House, Chicago, Illinois.

September 9-13—The International College of Surgeons, 13th Biennial Congress, Waldorf-Astoria Hotel, New York City.

September 17-November 9—Occupational Medicine, postgraduate course, New York University, New York City.

September 17-21—American College of Chest Physicians, postgraduate course, Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, Warwick Hotel, Philadelphia, Pa.

October 2-5—American Roentgen Ray Society, Shoreham Hotel, Washington, D. C.

October 4-6—American Medical Association First National Congress on Mental Illness and Health, Palmer House, Chicago, Illinois.

October 15-19—American College of Surgeons, Clinical Congress, Atlantic City, New Jersey.

October 17—Society for Adolescent Psychiatry, New York City.

October 20-26—Annual Otolaryngologic Assembly, postgraduate course, University of Illinois College of Medicine, Chicago, Illinois.

October 21-26—American Society of Anesthesiologists, Inc., Statler Hilton Hotel, New York City.

October 22-23—American Cancer Society, Biltmore Hotel, New York City.

October 22-26—American College of Chest Physicians, postgraduate course, Clinical Cardiopulmonary Physiology, Knickerbocker Hotel, Chicago, Illinois.

October 26-30—American Heart Association, Inc., Sheraton-Cleveland Hotel, Cleveland, Ohio.

October 27 - November 1—American Academy of Pediatrics, Palmer House, Chicago, Illinois.

October 28-31—American College of Gastroenterology, The Morrison, Chicago, Illinois.

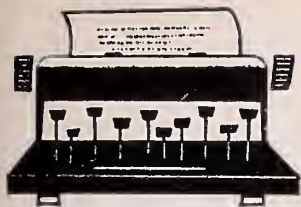
November 4-9—American Academy of Ophthalmology and Otolaryngology, Las Vegas Convention Center, Las Vegas, Nevada.

November 12-16—Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, Barbizon-Plaza Hotel, New York City.

November 25-28—American Medical Association, Clinical Meeting, Los Angeles, California.

December 1-6—American Academy of Dermatology, Inc., Palmer House, Chicago, Illinois.

June 16-20, 1963—AMA Annual Meeting, Atlantic City, N. J.



One Vote — One Battle Won

The Brief Recall of Thomas Jefferson

NOT OFTEN IN HISTORY does an issue present itself to the Congress and to the people where the good and the bad are so easily distinguishable and adequately delineated as to facilitate a quick and easy decision. The merits and demerits of a given controversy have a way of fusing together to produce a gray effect that often fogs the mind and obscures one's ability to see clearly the end product in full bloom.

The great domestic debate on Social Security financing for health care to the aged seems well qualified by both descriptions: the first natural, the second man made.

To the majority of thinking Americans who still believe that "those who are governed least are governed best," the bad inherent in the Administration's "medicare" bill clearly outweighed the good.

The last ditch "bi-partisan" modified version of the King-Anderson Bill offered in the Senate did little to remove the basic objectionable features; namely that the program was built on the shaky sands of compulsion and offered little to the American people but increased taxes, further government encroachment, expanded bureaucracy and the surrender of additional state and individual rights.

The maneuver to force a Senate vote on a bill acknowledged by most political observers to have practically no chance of survival in the House revealed the true political motives of the promoters of this election gimmick.

By forcing a favorable vote in the Senate the Administration would have sought to create the impression that the majority of the people favor the Social Security approach to this matter. In a word "it just weren't so." And the 52 to 48 Senate vote, close as it was, proves the point. We in no way wish to sound as though we are crowing over our victory. The margin was too slim for that, and like bad money, this issue will keep coming back until it is

buried so deep as to discourage any serious attempt to revive it.

The stargazers, the social planners and others deluded by their self acquired political importance seemingly never know when to stop pushing. Herein may lie the genesis of their own set-back. For in resorting to their peculiar brand of lopsided statistics, reckless accusations against opponents of the bill, and distorted claims as to the actual worth of the program, they simply oversold their product. When time came for them to deliver in the great deliberative body of the United States Senate, their program looked extravagant, ill-advised and completely unwarranted by the facts at hand. And so it was.

Apparently one of the big mistakes of the strategists for this bill was in presenting it as an either/or proposition. In choosing to ignore the effect of voluntary health insurance and the Kerr-Mills Law, proponents of King-Anderson type legislation admonished the Congress to either enact the bill or stand naked before 17 million aged persons accused of callous disregard for their health and welfare. The Congress simply wasn't buying—at least not now.

Platform and other campaign promises notwithstanding, the Kerr-Mills Law deserved a chance to prove its value in this field, and with more than 53 per cent of the over age 65 group already covered by health insurance, the Congress reacted calmly to the insistent demands for immediate enactment of this legislation.

Proponents of the program have seized upon their own defeat to beat the drum for the election of more people like those whose position was out voted in the Senate last month. It would seem that this is sufficient warning to all that this issue is sure to come up again in the next Congress. We have been promised by no less than the President himself that it will.

During the months between now and January 1963 we must take our message to every nook and cranny in Georgia and, indeed, throughout the country. We must utilize this time to work for greater improvements in the voluntary insurance field and in the Kerr-Mills program. An effort, much greater than anything we have done in the past, must be made to get our message across to the people. Our cause is right and just, but unless we impart, in detail, our own convincing justification for the stand

we have taken in this fight, we will have failed with the people. Their support over the long haul is essential if we are to contain those forces seeking to regiment and control the practice of medicine.

Almost 200 years ago Thomas Jefferson said that "eternal vigilance is the price of liberty." Like a thunderbolt sanctioned on Mount Olympus, the truth of this great man's simple utterance came home to the Senate and the American people last month. We have won a battle—an important battle—but we have not won the war. We must not fail now to rally for the final and ultimate victory.

Doctors Speak Out with Truth

BY NOW MOST EVERYBODY WHO READS the Atlanta newspapers is aware of an editorial which appeared in the evening issue of June 18th, alleging among other things, that the AMA does not represent the doctors' views on the issue of Social Security medicine.

The article was inaccurate and misleading to say the least. However, this is not an attempt to take to task that bit of irresponsible editorial expression. This has already been ably done in the public press by physicians who were amazed that such a thing should have been printed in the first place. In fact it is their spontaneous and unsolicited response to that editorial which we feel is deserving of special comment here.

We have no way of knowing the exact number of written complaints received by the newspaper pursuant to that editorial. Judging from the number of published communications in the "Letters to the Editor" column we feel that they must have been considerable. Some were obviously written in haste and some were very eloquent. But coursing through all was a degree of unmistakable sincerity which we think was not lost on the reading public.

There is a fairly broad based feeling among many in the general public that doctors are politically shy and will usually go out of their way to avoid entanglements with politics, politicians, and those who earn their bread by writing about such matters. This theory, if we may call it that, traced back to the old expression that politics and medicine do not mix, possibly has about it an element of truth. However, that day has long since passed and the quick

response by doctors to correct the misinformation and erroneous opinions expressed in the June 18th editorial certainly proves the point.

Because of the nature of medicine, practitioners have, through the years, been pretty much left alone. As apostles of rugged individualism, physicians were never considered to be likely targets for government favors or government controls. While nobody questioned their membership in the body politic, the fact remains that for a good long time physicians were never fully integrated into the mainstream of American political life.

The threat of governmental dominion over the practice of medicine has changed all that, and the shy, retiring "practice-medicine-only" type is a relic that faded, not with, but about the same time as the smoke filled room and the other political pigpens of an almost forgotten past.

The significant thing about the response which the editorial in question drew is that it was swift, definite and wide-spread. It demonstrated a fundamental strength to the political side of the medical profession in its unity of expression and its adherence to the simple truth. It likewise revealed a vitality, a political awareness and above all a determination to fight back when the house of medicine is unfairly and incorrectly under attack.

MAG applauds and congratulates those physicians who moved quickly to set the record straight. There have been too many instances in the past when similar editorials and vocal expressions have gone unanswered and unchallenged. An unanswered charge repeated often enough usually becomes a fixed

truth in the minds of the people. The overwhelming rebuttal to this editorial makes it unlikely that this same material will be offered up again in the near future. If it should be, it is our hope that these same physicians will swing into action again. And that

they will be joined by others who will challenge the veracity of those who mistake their position for a license to misconstrue the truth.

Keep up the good work.

Proudly We Hail

THOSE PHYSICIANS WHO WERE PRIVILEGED to attend the recent Annual Session of the American Medical Association in Chicago were treated to a spectacular array of scientific and commercial exhibits in the new McCormack Place. This enormous exhibit hall was also the site of some of the most instructive scientific programs and panel discussions ever scheduled at an AMA meeting.

The most satisfying and rewarding experience for many of those in attendance was a feeling that pervaded the business meeting and the sessions of the House of Delegates. The feeling was one of a unity of purpose in American Medicine—a unity which supersedes any small differences that may arise from time to time between the various specialties or groups within the profession. This unity has been forged by those forces from outside the profession which would seek, by devious means, to undermine the very foundations of our American system for the private practice of medicine.

Elsewhere in this issue is reproduced the address given by Dr. Leonard Larson, the retiring President

of the American Medical Association. In his address he eloquently summarizes the historic events of the past year—how the doctors of this country have closed ranks and have gone directly to the people to warn them of the consequences of a federal government administered system of medical care. We as physicians have won the first *battle*, but the *war* is not yet won.

The really significant factor is that we and the American people are at last alerted to the danger, and we have proven ourselves both willing and able to take a strong unified stand against what we know to be wrong. We are not only confirming our roles as the guardians of the nation's health, but we are also proving ourselves to be fulltime citizens who are concerned for our country's future.

With this pride in our response to the threat of the past year, we can look toward the future with confidence and pride. The war is not won, but our forces have distinguished themselves. We may justly be proud of our profession.

AMEF CONTRIBUTORS

Name	Address	Name	Address
Austin, Jack	Griffin	Martin, John, Jr.	Atlanta
Burleigh, Bruce	Marietta	Mitchell County Woman's Auxiliary	Camilla
Bibb County Medical Society	Macon	Medical Assn. of Ga. Woman's Auxiliary	Atlanta
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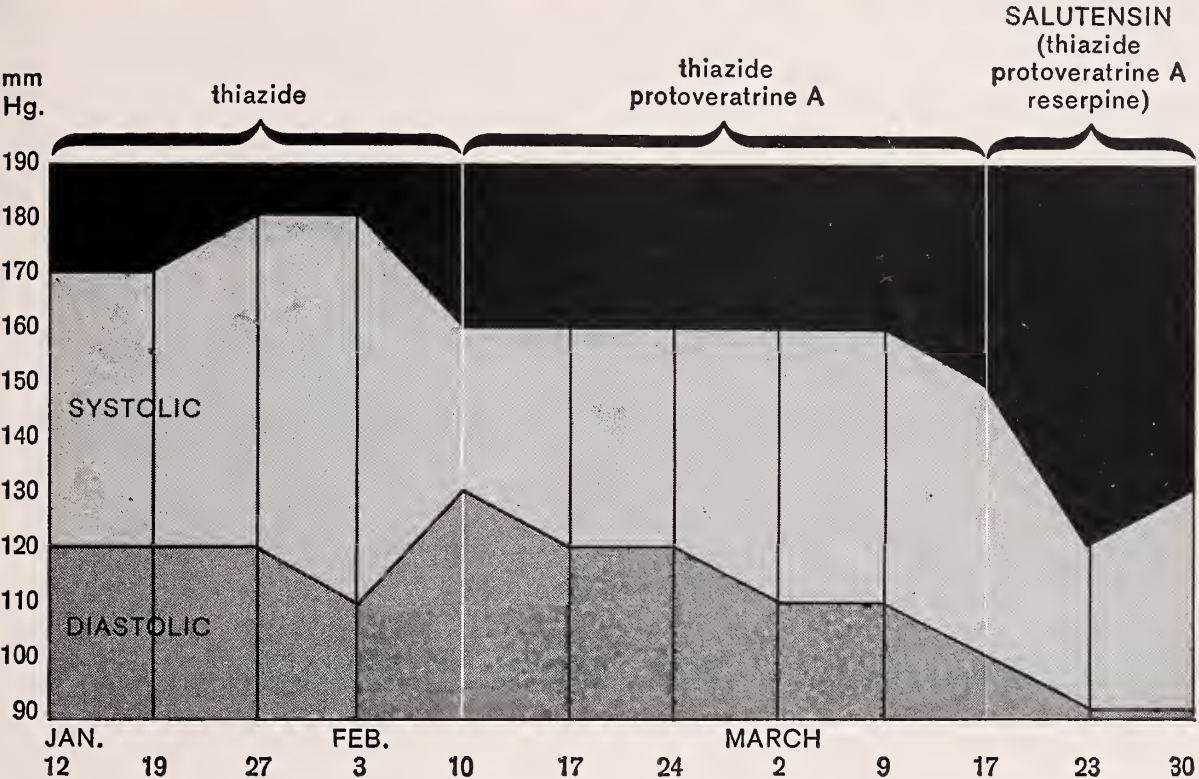
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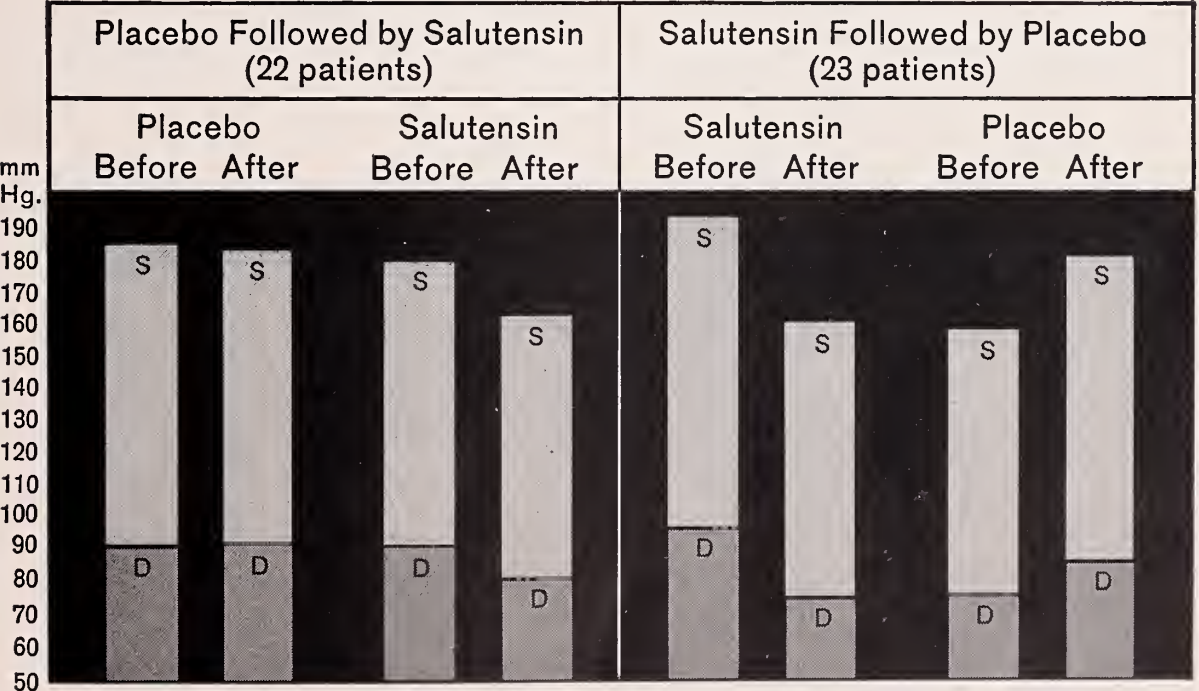
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11 WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS BY SERIAL ADDITION OF THE INGREDIENTS IN SALUTENSIN IN A TEST CASE

(Adapted from Spiotta, E. J.: Report to Department of Clinical Investigation, Bristol Laboratories)

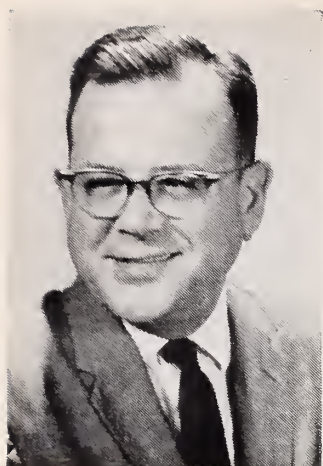


3½ WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS USING SALUTENSIN FROM THE START OF THERAPY IN A "DOUBLE BLIND" CROSSOVER STUDY
Mean Blood Pressures—Systolic (S) and Diastolic (D)



In this "double blind" crossover study of 45 patients, the mean systolic and diastolic blood pressures were essentially unchanged or rose during placebo administration, and decreased markedly during the 25 days of Salutensin therapy. (Smith, C. W.: Report to Department of Clinical Investigation, Bristol Laboratories.)





PRESIDENT'S LETTER

"A TALE OF TWO CITIES"

THOMAS W. GOODWIN, M.D.

THE month of June was a busy one for your President. In the early part of the month it was my privilege to go to Washington with our delegation to make our annual call on our Senators and Representatives. This, I believe, is one of the most worthwhile things that our Association does. The make up of the delegation varies from year to year. It is composed of one representative from each congressional district in the State and certain selected officers of the Association. The entire delegation usually calls upon our Senators and the representative from each district then calls upon his own individual congressman. We also entertain our representatives in Congress with a luncheon which is held in the Speaker's Dining Room in the Capitol.

We all felt that this year's trip was one of the most successful ones that has been made. It was a delightful experience to exchange views with our people in Washington. You may rest assured that the thinking of the Medical Association of Georgia in regard to matters pertaining to medical care and medical education were well presented.

The latter part of the month found your President at the annual session of the American Medical Association in Chicago. There it was my privilege, along with the other 51 state and territorial Presidents, to participate in the Inaugural Ceremony of the new President of the American Medical Association. This was the first time that the state presidents had taken part in this ceremony and all agreed that it was very impressive and symbolically illustrated the unity of the component societies of the American Medical Association.

The meeting itself was somewhat overwhelming due to its tremendous size. The House of Delegates sessions were of great interest to me. The various issues confronting medical practice were well considered and debated with good decorum and order. You may be sure that whatever decisions were made were made with the welfare of each doctor in the United States at heart. The American Medical Association is no more perfect and perhaps no less perfect than any similar large representative body. I was, however, impressed by the fact that in its reference committee hearings and in its House of Delegates, objective, factual criticism is desired, welcomed, and accepted without resentment.

We can all be very grateful that we still have the right of free speech in this country. That we can still discuss the things which affect our welfare freely, both with our elected law-makers in Washington and with our elected policy-makers in the higher councils of the American Medical Association. Of such stuff is democracy made.

Thomas W. Goodwin
President, Medical Association of Georgia



PSYCHOTHERAPY IN GENERAL PRACTICE

Donald D. Lathrop, M.D., *New Orleans, Louisiana*

THERE ARE SEVERAL NOTIONS about psychiatric illness of patients seen in general practice with which I would like to take issue. It is widely publicized that three-fourths of the patients consulting their family doctors suffer *primarily* from their "nerves." Recently, it has also been strongly suggested that the G.P. should be a super-specialist and among other things, a psychotherapist.

I had a unique opportunity to find out for myself about these contentions. After one year of psychiatric training, I went back to small town general practice for two months. Then after two years of psychiatric training, I again became a G.P. for a month. On the second occasion, I collected a little data. On each initial visit I made a notation of the *primary* reason for the patient consulting the family doctor. Of 175 initial visits, 70 per cent were for physical illness, 20 per cent were for clearly diagnosable psychiatric conditions, and ten per cent were a mixture of which I could not decide which was the primary problem.

Obviously, this does *not* prove anything. The circumstances and the technique of the study do not meet rigid scientific methods. It did convince me, however, that most patients in private general practice are not simply "neurotics." They (and we) *all* have problems, we all have emotional conflicts, we all have personalities. Some people's personalities are irritating to other people's personalities (including physicians). These people are often called "neurotic" as a term of disgust.

I am convinced that the vast majority of patients consult their family doctor because they want a specific service. If they have an illness (pain), they want cure (relief from pain). If the doctor cannot cure the illness, he is expected, at least, to know what is wrong and to give comfort based upon his knowledge.

People going to a psychiatrist generally expect

their minds to be examined. They expect to be asked questions about their thoughts and feelings, some of which will be embarrassing. I became sharply aware of the difference between expectations people have of a psychiatrist and a family doctor when I went from being psychiatrist on Friday to being a general practitioner on Monday. People expect the family doctor to be interested in their bodies, not their Oedipus Complex. Furthermore, the psychiatrist sells time; the G.P. sells service. The more service the G.P. gives in a day, the more money he makes. He cannot afford the luxury of giving away his valuable time any more than the psychiatrist can. These realities of life are often overlooked by academicians.

What then of the 20-30 per cent of patients in my study with psychiatric illness? Of these, about two-fifths were suffering from disorders for which the psychiatrist would have very little to offer—chronic psychoses, organic brain disease, and character disorders (such as "psychopathic character"). Another two-fifths had psychosomatic illness (asthma, arthritis, hypertension, etc.), which are also not often amenable to psychotherapeutic help. The remaining one-fifth were the depressives, the hysterics, and the borderline psychotics. These are the patients the psychiatrist can generally help considerably. However, in my "study," I felt that only one patient could really stand psychiatric referral. The others were either not capable of helping themselves or were unapproachable concerning the idea that their primary problems were emotional.

This seems discouraging. If even a third of the family doctor's patients suffer primarily from mental illness; and if very, very few of these can be gotten to the psychiatrist; and if it is not practical to make a psychiatrist out of the G.P., then what to do? Fortunately, the good G.P. has always known the

MENTAL HEALTH / *Continued*

answer; treat the patient with the knowledge and techniques that are available and practical; kindness, understanding, sympathetic interest, advice, education—sometimes criticism, authoritarian pronouncements, sometimes manipulation of the environment and always *pills* (and often shots). These are the appropriate “psychotherapeutic” measures for the G.P.

Is nothing more to be expected of the G.P.? Yes. He needs to learn more about the basic dynamics of the human personality. Medical psychology must, some day, become as basic and important as anatomy and pathology. With more knowledge, the G.P. can make a *positive* psychiatric diagnosis. The

present tendency is to make a psychiatric diagnosis by exclusion or because the doctor is angry at the patient (usually for not getting well). With a psychiatric diagnosis based upon knowledge, the family doctor will be better able to make a good psychiatric referral. He would be sending patients who are likely to be helped and sending them with a feeling that their family doctor wants them to feel better—not to get rid of them.

And, finally, a positive psychiatric diagnosis permits better management. Knowing the diagnosis, knowing what it means in terms of the patient's functioning, knowing the prognosis, and knowing the best drugs to use for that condition make the G.P. a good doctor—whether the illness is mental, physical, or both.

Prepared at the Request of the Committee on Mental Health of the Medical Association of Georgia.

THE AMA NATIONAL CONGRESS ON MENTAL ILLNESS AND HEALTH

The American Medical Association will hold its first National Congress on Mental Illness and Health in Chicago, October 4-6.

The purpose of this Congress, held with the cooperation of the American Psychiatric Association and the support of the National Association for Mental Health, is to implement the broad, new mental health program developed by the AMA's Council on Mental Health. This program represents years of study and discussion and draws heavily upon sources such as *Action for Mental Health*, the AMA's Preliminary Conference on Mental Illness and Health, and meetings with the chairmen of the AMA's State Committees on Mental Health.

The three days of the Congress will be devoted to planning specific activities implementing the AMA program. There will be no formal presentation of papers or discussions leading to new position papers on mental health problems—the guidelines for the Congress are spelled out in the program. Participants will meet in both topical and regional discussion groups to develop

coordinated and continuing mental health programs to be carried out at the national, state and local levels.

The topical meetings at the Congress will cover 21 subjects including research, hospital and community programs, personnel recruitment, and physician education. Material developing from these discussions will then be brought up in the regional workshops. This format allows participants to first consider problems of special interest, decide on priorities for subsequent action in their state or region, and then transform these considerations into positive programs tailored to the needs of their particular geographic area.

The American Medical Association hopes that as many physicians and interested citizens as possible will take part in the Congress. It also hopes that the participants will return to their respective states ready for action. The success of this Congress and the AMA program can only be measured by the positive steps taken by the conferees in the months and years following the meeting.

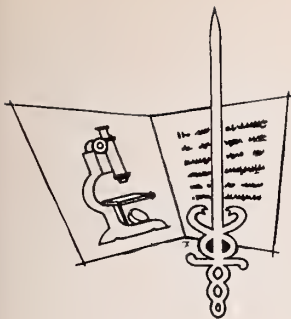
Mark These Dates On Your Calendar

May 5-8, 1963

109th Annual Session of

Medical Association of Georgia

Jekyll Island, Georgia



CANCER OF THE COLON

A. B. Conger, M.D., *Columbus*

IN ORDER to cure more cases of cancer of the colon, we must make the diagnosis earlier. This point cannot be overemphasized. The only way we can save more people with cancer of the colon is to get more of them at a time when their lesion is amendable to surgical intervention. This concept requires knowledge on the part of the patient of the danger signals of cancer of the colon. It requires adequate history taking, routine use of the sigmoidoscope, and x-rays of the colon (where indicated) on the part of the physicians.

The mortality rate following resection of the colon has improved greatly during the past three or four decades. Forty years ago it was 20 to 25 per cent, whereas now it is no more than two to five per cent. On the other hand, the five-year survival rate in patients surviving curative resection has improved very little during this period. For example, in 1941, Mayo and Lovelace¹ reported a five-year survival rate (exclusive of operative deaths) of 57 per cent in patients with cancer of the right colon operated on between 1907 and 1938; in 1942, Lahey and Sanderson² reported a five-year survival rate of 57 per cent in their patients with cancer of the colon. These figures are comparable to those reported during recent years. This lack of improvement in the five-year survival figures is explained by the fact that we are not being successful in our efforts to get the patient to the operating room earlier. The delay between onset of symptoms and operative resection still extends over a period of months or years. We must exert greater effort in our educational campaign to seek a diagnosis earlier.

At the present time, no more than 60 to 62 per cent of patients with cancer of the colon coming to the operating room have lesions early enough to permit curative resection. In a series of 4,850 pa-

tients with cancer of the colon or rectum reported in 1956, Collier³ and associates reported that curative resection could be performed in only 61.2 per cent of cases. Similarly, in 1956, Swinton⁴ reported a curative resection in only 63 per cent of 901 patients with cancer of the colon or rectum. The operability with cancer of the rectum is relatively equal in the two groups. From the Mayo Clinic, Griffin⁵ and associates reported a curative resectability of 70.3 per cent in cases treated between 1939 and 1948, and that in 1952 it was unchanged.

From the standpoint of the operation itself, points which still need to be emphasized are these:

1. Adequate pre-operative preparation of the patient which includes correction of nutritional deficiencies, correction of anemia, and thorough sterilization and cleansing of the bowel.
2. The tumor should be manipulated as little as possible to determine its attachments and operability, and this should be done gently.
3. A search should be made for more than one tumor because in six to eight per cent of patients, more than one tumor of the colon would be found.
4. The lumen of the bowel should be ligated with tape several inches proximal and distal to the tumor. This minimizes dissemination of cancer cells through the lumen of the bowel to the area involved in the anastomosis.
5. The vascular trunks leading to the tumor area should be ligated preliminary to operative manipulation. This, of course, will also include ligation of most of the lymph vessels.
6. A wide resection of the bowel should be done. It is a standard procedure to excise the entire right colon for lesions of the cecum or ascending colon, but the best thinking on this subject

now advises removal of the entire transverse colon including the two flexures when the carcinoma is located in the transverse colon. When the carcinoma is located in the left colon, the bowel and mesentery for several inches above the tumor and a few inches distal to the tumor must be excised. It is still felt by most surgeons that any carcinoma distal to the peritoneal fold of the recto-sigmoid should be treated with a combined abdomino-perineal resection.

In summary, earlier diagnosis and more careful

and thorough resection of the bowel can save a great many more patients with cancer of the colon than are being saved at this time.

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2. Lahey, F. H., and Sanderson, E.: Lesions of the Right Colon Involving Right Colectomy. *J.A.M.A.* 120:1356, 1942.
3. Collier, F. A.; Ranson, H. K., and Regan, W. J.: Cancer of the Colon and Rectum. Published by the Am. Cancer Soc. 1956.
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Approved by Professional Education Committee, Georgia Division, ASC.

SELECTIVE SERVICE DEFERMENT OF RESIDENTS AND INTERNS

Recent discussions with the National Advisory Committee on the Selection of Physicians, Dentists and Allied Specialists have clarified several issues arising from the recently accelerated program of drafting interns and residents into military service. There is no basic change or new administrative regulation concerning the method of drafting physicians. Selective Service officials, although aware of the educational value of hospital residency programs, are finding it necessary to use the draft mechanism to bring into the armed services the number of physicians now needed.

Defense Department as well as Selective Service officials advise that if each draft-age doctor keeps his local Selective Service board informed of his residency status, and if each hospital administrator keeps fully informed of the military classification of his house officers, the draft problem can be greatly alleviated. Selective Service officials plan to publish specific bulletins to provide doctors and hospitals with all necessary current information about the accelerated draft.

Meanwhile, there are a number of steps which both residency candidates and hospitals could and should take to avoid unnecessary disruption of training programs:

1. Prospective residents will be automatically classified 1-A upon completion of internship. It is essential that the prospective resident notify the proper Area Board about his appointment. The proper Area Board is that which has jurisdiction over the locale of the hospital to which he is

appointed. Selective Service officials emphasize that such notification of the Area Board in no way will reflect on the resident's status with his own local board. If the prospective resident waits until he receives a 1-A classification notice from his local board, he has only ten days in which to make an appeal. Failure to appeal within the ten-day period will nullify his right to appeal.

2. Hospitals should ask all candidates for residency positions to furnish their Selective Service numbers, their draft classifications, and the addresses of their local boards. Selective Service officials recommend that the hospital notify the respective local boards of the effective dates of each resident's appointment. This notification is not an appeal, but it informs local boards of facts which may help in making a judgment on a draft candidate's change of status. An appeal from a draft status should be directed to the Area Board. The appointing hospital may, of course, support the prospective resident's appeal by letters to the Area Board.
3. Because the present national emergency is likely to be of extended duration, Selective Service officials urge hospitals to consider carefully the draft status of each prospective resident. It is recommended that, to the extent feasible, a hospital appoint draft-exempt candidates in sufficient proportion so that continuity of its residency program may be maintained.



ACUTE ARTERIAL EMBOLISM

Pierpont F. Brown, Jr., M.D., *Gainesville*

ACUTE ARTERIAL OCCLUSION may be caused by an embolus or a thrombus and in either case presents an emergency situation. Sudden thrombosis is usually associated with underlying arterial disease such as atherosclerosis, while the source of emboli is usually the heart. While both conditions require emergency measures to insure the life of the patient and the preservation of the extremity, this short report will deal only with the problem of emboli.

Arterial emboli may arise from aneurysms or from thrombi associated with arteriosclerotic plaques but the vast majority arise from a mural thrombus within the heart. Conditions predisposing to mural thrombi are myocardial infarction, rheumatic heart disease, and auricular fibrillation. Embolism following myocardial infarction usually occurs from one to several weeks after the infarction. An embolus is especially apt to occur in a patient with auricular fibrillation when the arrhythmia is reverted to a normal rhythm. Emboli may arise from vegetative endocarditis, but they are rarely large enough to occlude a major artery.

The symptoms of a peripheral embolism have a rapid and sudden onset with pain, coldness, and numbness of the extremity. Paralysis may be present. Emboli not only find their way to the extremities but may also occlude the mesenteric vessels or the carotids. The possibility of this should be thought of in the differential diagnosis of an acute abdomen, especially in the cardiac patient.

Embolitic occlusions usually occur at the bifurcation of arteries where there is a sudden decrease in the caliber of the vessel. The bifurcation of the abdominal aorta, the internal and external carotid, internal and external iliac, the deep and superficial femoral and the popliteal are the most frequent sites. Due to functioning collaterals the skin temperature change is usually somewhat lower than the location of the embolus. The temperature change is located

just below the knee when the femoral vessel is involved and the change is lower in the leg or foot when the popliteal vessel is the site of the embolus.

Embolectomy of a major peripheral artery should always be performed unless there are strong systemic contraindications. Our first thoughts in the treatment of embolism are concerned with the life of the patient; secondly, the viability of the involved extremity; and thirdly, the reduction of late residual ischemic symptoms. Time is most important for successful embolectomy, and results are much better when surgery is carried out within the first six or eight hours following embolism. After this time distal thrombosis is most likely and irreversible tissue changes may result. The immediate administration of heparin may help protect the patient against distal propagation of the clot and distal thrombosis. The overall condition of the patient must be evaluated and measures taken to correct any situation feasible prior to surgery. Usually it is the underlying cardiac condition of the patient that is most important in the prognosis. Treatment of heart failure, arrhythmia, or shock may be necessary before surgery can be carried out. The patient should be protected with heparin during this phase of treatment.

Although results are much better in patients operated within six or eight hours, embolectomy should be offered to patients with embolism of many hours longer duration. The only real contraindication to surgery is irreversible tissue ischemia. If the collateral circulation has helped keep the blood liquid distal to the clot and prevented distal thrombosis, later embolectomy has some chance of being successful. With late embolectomy subsequent amputation may be possible at a lower level.

As stated before, embolectomy should be carried out on all patients unless there is some systemic contraindication or unless there is irreversible tissue ischemia. In the presence of partial occlusion with

a viable extremity there may be a tendency to depend upon anticoagulants, sympathetic blocks, and other conservative measures. However, there will be the possibility of late ischemic symptoms which may be disabling. We do not delay the preparation of the patient and surgery for performance of sympathetic blocks, but proceed with heparinization and surgery.

Surgery can be carried out under local or spinal anesthesia for lower extremity embolectomy or local anesthesia for an upper extremity embolus. Aortic or iliac embolectomy may be done under spinal or general anesthesia if the patient's condition permits. Many prefer spinal anesthesia for the sympathetic block effect. When performing an embolectomy in the lower extremity, the entire extremity should be exposed and prepared. It may be necessary to make a more distal arteriotomy incision before adequate back flow is obtained, or the technique of flushing the posterior tibial artery may be necessary. A successful embolectomy necessitates a good distal back flow. Space does not permit a detailed description of the surgical technique.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

Attention should be called to the increasing number of reports of successful embolectomy of the superior mesenteric artery. As with embolectomy of other arteries, the time of diagnosis and treatment is most important. Usually by the time the diagnosis is made, massive intestinal resection is necessary. The diagnosis of superior mesenteric arterial embolism must be entertained when there is severe, crampy abdominal pain, nausea and vomiting, and increasing leukocytosis in a cardiac patient. Many of the signs of an acute abdomen do not appear until later when thrombosis and tissue ischemia are established.

Postoperatively, anticoagulant therapy may play a great part in prevention of subsequent embolism. The treatment of the patient's underlying cardiac condition must be continued.

In conclusion, we may say that the time of diagnosis and treatment of acute arterial embolism is one of the most important points in the management of this type of sudden arterial occlusion. This is an emergency situation that requires immediate evaluation, accurate diagnosis, and treatment. The life of many patients can be saved, many extremities can be salvaged, and many late ischemic symptoms can be prevented by early embolectomy.

PROFESSIONAL TEACHING FILMS TO BE PRODUCED

Physicians and medical students in the United States and abroad will have an opportunity to further their education under notable authorities in the field of medicine through a series of professional teaching films, entitled "Clinical Entities."

The series is being produced by the Wayne State University College of Medicine under educational grants from Eli Lilly and Company.

"Diabetes in Youth," the first in the series, had introductory showings at the 1962 conventions of the American Medical Association and the American Diabetes Association in Chicago. It features lectures and case studies by the staff of the famous Joslin Clinic, Boston.

The second of the series, "Angina Pectoris," and the third, "Coronary Occlusion," are both by Samuel A. Levine, M.D., Clinical Professor Emeritus of Medicine, Harvard Medical School, Boston.

Other films in the series are being planned.

The movies will be made available on temporary free loan to medical teaching institutions — to medical schools, medical societies, hospitals, state, county, and city health departments, and medical conventions in this country and abroad. Distribution is from the Audio-Visual Utilization Center, Wayne State University, Detroit 2, Michigan. The films also may be purchased at cost from the center.

The diabetes film will be ready for general release about August 1 and the other two at a later date.

The Wayne State director of the series is Frederick J. Margolis, M.D., and the producer is Rex Fleming, Santa Barbara, California.

Dr. Margolis said that the university medical school has been producing medical teaching films for a number of years. He expects this series to be particularly successful because of the co-operation of top authorities in medicine and because of the increased stress put on continuing medical education by the American Medical



BOOKS RECEIVED

Finneson, Bernard E., M.D., **DIAGNOSIS AND MANAGEMENT OF PAIN SYNDROMES**, W. B. Saunders Co., Philadelphia and London, 1962, 261 pp., \$8.50.

Nealson, Thomas F., Jr., M.D., **FUNDAMENTAL SKILLS IN SURGERY**, W. B. Saunders Co., Philadelphia and London, 1962, 289 pp., \$8.50.

Robbins, Stanley L., M.D., **TEXTBOOK OF PATHOLOGY**, Second Edition, W. B. Saunders Co., Philadelphia and London, 1962, 1190 pp., \$19.00.

McLennan, Charles E., M.D., **SYNOPSIS OF OBSTETRICS**, Sixth Edition, The C. V. Mosby Co., St. Louis, Mo., 1962, 464 pp., \$6.75.

STRABISMUS, Symposium of the New Orleans Academy of Ophthalmology, The C. V. Mosby Co., St. Louis, Mo., 1962, 369 pp., \$18.00.

Wolstenholme, G.E.W., O.B.E., and Cameron, Margaret P., CIBA Foundation Study Group No. 9, **PROGESTERONE AND THE DEFENSE MECHANISM OF PREGNANCY**, Little, Brown and Co., Boston, 1962, 108 pp.

Mongar, J. L., Ph.D., and de Reuck, A.V.S., M.Sc., CIBA Foundation Symposium on **ENZYMES AND DRUG ACTION**, Little, Brown and Co., Boston, 1962, 556 pp., \$12.50.

Kobler, John, **THE RELUCTANT SURGEON**, Doubleday and Co., Garden City, N. Y., 1962, 439 pp., \$1.45.

Weber, Laura E., M.D., **BETWEEN US WOMEN**, Doubleday and Co., Garden City, N. Y., 1962, 153 pp., \$1.95.

Allday, R. K., M.D., **ON MEDICINE IN BRITAIN AND THE NATIONAL HEALTH SERVICE**, John Wright & Sons Ltd., Bristol, 1962, 62 pp., \$2.25.

Editors: Harrison, T. R., M.D.; Adams, Raymond D., M.D.; Bennett, Ivan L., Jr., M.D.; Resnik, William H., M.D.; Thorn, George W., M.D.; and Wintrobe, M. M., M.D., **PRINCIPLES OF INTERNAL MEDICINE**, Fourth Edition, McGraw-Hill Book Co., Inc., New York, N. Y., 1962, 1,947 pp., \$19.50.

REVIEWS

Yater, Wallace Mason, M.D., and Oliver, William Francis, M.D., **SYMPTOM DIAGNOSIS**, Appleton-Century-Crofts, Inc., New York, N. Y., 1961, 951 pp., diag., tables, \$15.00.

THE FIRST EDITION of this well known book was published in 1927, and the fourth edition appeared in 1942. The new, fifth edition has been extensively revised and brought up to date, with descriptions of some diseases, such as primary aldosteronism, which were not even known to exist at the time of the last edition.

The authors have a unique approach, stressing symptoms as they relate to the various regions of the body. For example, if the physician is confronted with a patient complaining of pain in the jaw, he simply turns to this section of the book and finds brief descriptions of some twenty-eight conditions which may cause this symptom.

Besides the twenty-one headings under "Regional Symptoms," there is a section called "General Symptoms," listing three pages of symptoms in this category. There follows, in a well organized manner, a brief de-

scription of the common and rarer causes of these general symptoms.

In addition, there are 18 concise tables of differential diagnosis, a list of "syndromes" and a list of diseases, symptoms, and signs associated with men's names.

The book is easy to use and should be especially helpful to the busy practitioner in reminding him at a glance of the many diseases that he must consider in arriving at a correct diagnosis on the basis of the symptoms which his patient presents.

Henry H. Tift, M.D.

Gregory, Ian, M.D., **PSYCHIATRY, BIOLOGICAL AND SOCIAL**, W. B. Saunders Co., Philadelphia, 1961, 557 pp., \$10.00.

DOCTOR GREGORY'S BOOK presents an eclectic approach to psychiatry, integrating material from the major schools. He does not favor any special viewpoint such as biological, psychoanalytic or socio-cultural but presents a balanced viewpoint of both European and American concepts within the broad framework of both the international statistical classification and the standard nomenclature. The approaches to treatment include both directive-organic and analytic-psychological methods. He integrates biological and psycho-socio-cultural research in etiology. The book is divided into *two* parts, the first dealing with general principles, and the second dealing with specific syndromes. Each classification is presented in a sequence leading from definition to investigation to treatment to etiological hypothesis. There are a few tables which make the text material more easily understandable and which facilitate differential diagnosis. The importance of heredity and the operation of hereditary factors is treated in considerable detail. There is some over-presentation of statistical material which has many limitations and, therefore, has questionable usefulness.

There are a number of typographical errors such as on page 182 where 8-6 is used for 86, on page 383 where the word "mission" is used for "remission" and on page 480 where the last sentence appears to have a portion omitted.

This volume should be very useful to the medical student as an introduction to psychiatry. Physicians other than psychiatrists who are interested in acquainting themselves with psychiatry will find this volume very readable and useful.

Joseph S. Skobba, M.D.

SOMATIC STABILITY IN THE NEWLY BORN—A Ciba Foundation Symposium.

THE CIBA FOUNDATION has published another of its rather exhaustive symposia, this time exploring the realm

PHYSICIAN'S BOOKSHELF / Continued

of the newborn, both premature and full-term, covering most aspects of anatomical and biochemical development, as well as physiologic function.

Each chapter by a different author is a paper, delivered before a January 1961, meeting of 30 well-known physicians and researchers in London. Together they form a comprehensive survey of the subject, from a discussion of nutrition and development of animals at birth, (one on the metabolic rate and body temperature of pigs and the physics and physiology of homoiothermy); to the more practical ones on endocrine function of the newborn, stability of the cardiovascular system, and (probably the paper of most value to the practitioner) the respiratory distress syndrome of prematurity.

Following each chapter is a lively discussion section, where all the participants air their views on the various subjects. These sections are informal, full of quotes such as "I seem to remember having heard it said that in chorioepithelioma there is a lot of fructose around," and tend to break up the sometime overly pedantic formal papers.

Olin Shivers, M.D.

TEXTBOOK OF ENDOCRINOLOGY, Third Edition, Edited by Robert H. Williams, M.D., W. B. Saunders Co., Philadelphia, 1962, 1204 pp., \$21.00.

THIS HIGHLY successful text has been available only twelve years and is now in its third edition (1962), with sales increasing annually. The new volume has been expanded to include new spheres of the rapidly developing field of endocrinology, along with the old "standby" chapters which are, for the most part, totally rewritten to keep pace with the '60's. The number of contributing authors has been doubled, and all are nationally known in their field.

The authors screened hundreds of articles published annually concerning endocrinology and metabolism, and picked out the "meat" for the medical profession. Eight entirely new chapters are presented, some of which are, "The Pineal," "Disorders in Sex Differentiation," "Genetics and Endocrinology," "Lipid Metabolism and Lipopathies," "Hormones and Cancer," and "Hypoglycemia and Hypoglycemoses." Pathophysiology is emphasized, along with pertinent clinical diagnosis and management. The last two chapters explain the laboratory tests which are currently available and the hormone preparations on the market.

Without hesitation, this textbook can be recommended to medical students, interns, endocrinologists, gynecologists, etc. Almost every specialty in medicine today comes in contact with endocrine problems and this work should become the new standard for comparison.

James Z. Shanks, M.D.

FINANCING MEDICAL CARE, Helmut Schoeck, The Caxton Printers, Ltd., Caldwell, Idaho, 1962, 314 pp., \$5.50.

THIS IS the first book to provide an inside look at the various systems of compulsory health insurance found in many foreign countries. It is excellent reading for anyone seeking the answer as to whether the United

States is lagging behind social progress and the march of history by not having compulsory and comprehensive health insurance under government auspices.

It is rather difficult to obtain certain valuable evaluations of many programs of compulsory health insurance from some of the countries with monopolistic governments, but reliable reports show a general disenchantment with this system of medical care.

Compulsory health programs have generally been introduced in countries at a time when the economic future has been dismal. It has usually been imposed at first upon a particular segment of the population or a certain "biological group," but history proves that this is but a "foot-in-the-door" approach to imposition on all the citizens. The Marxist argument is for an inevitable evolutionary march of medicine to a welfare state, step-by-step. Once this autonomy is attained, the actual benefits of such a system erode.

Professor Schoeck has invited 15 experts abroad to report on medical systems as they exist today in foreign countries.

Preston D. Ellington, M.D.

MIDWIFERY BY TEN TEACHERS, Tenth Edition, Edited by Frederick W. Roques, John Beattie, and Joseph Wrigley, Edward Arnold Ltd., London, 1961, 739 pp. (The Williams and Wilkins Co., Baltimore, exclusive agents in U.S.A.)

JUDGING FROM the introduction, *Midwifery by Ten Teachers*, has probably been tucked under the arms of countless medical students in the British Isles since the first edition in 1917. The fundamentals of obstetrics are presented in a concise, readable fashion—a situation frequently noted in British texts. One does not find bibliographies, credit given to the authors of various procedures or facts, or detailed explanations underlying certain phenomena as seen in either *Williams Obstetrics* or that by DeLee and Greenhill. Rather this is an extremely practical volume with emphasis on the details of patient care.

Against this background, it seems unnecessary (and perhaps alarming to the student) that so much space has been devoted to interval versions and the destructive obstetrical procedures. A very graphic description of "the eclamptic Fit" in the chapter on toxemia would reinforce anyone's program of prenatal care. However, since there are a significant number of home deliveries in the British Isles, perhaps the neglected case is seen and referred to the hospital or clinic.

Of particular interest are the obstetrical practices which vary with those in this country: very little sedation with encouraged ambulation in the first stage of labor, use of the left lateral position for delivery, omission of routine episiotomy of perineum, bed rest until the fourth post-partum day and home on the tenth day, complete (rather than assisted) breech extraction.

The easy style and conversational tone of this book recommend it to the obstetrician interested in British obstetrical practices. Also nurses who specialize in obstetrics will find this book very helpful. But the medical student in this country should concentrate on one of the standard American texts for his primary source of information.

Charles K. Wright, M.D.

J. M. A. GEORGIA

THIS IS ONE of the Lange Publication books, all of the handbook variety, and all, to a degree, useful. This volume deals primarily with internal medicine disorders, although the most commonly encountered maladies of the other specialties are included. There are twenty-eight headings dealing with as many disease entities, and these are further broken down into headings of Diagnosis, Clinical Features, Treatment, and Prognosis. Pathological physiology is, for the most part, deleted, but the authors remind the reader that this book is not intended as a substitute for a comprehensive textbook of medicine.

Most chapters accomplish the purpose of being quick references of current diagnosis and treatment. The "Diet" chapter is inadequate both in coverage and sample diets; but the chapter on "Poisons" is surprisingly good in its conciseness and scope of information. One feature which this reviewer particularly liked is the location of the "Normal Values." They are placed on the front and the back covers, and are thus readily available.

One cannot become enthusiastic about a book of this type. However, it should not be condemned too vigorously. It is a concise, easy to read volume which will find its way into many emergency rooms and medical students' bags.

E. Walter Hood, M.D.

RENAL BIOPSY, CLINICAL AND PATHOLOGIC SIGNIFICANCE, Ciba Foundation Symposium, G. E. W. Wolstenholme and Margaret P. Cameron.

ACCURATE CONCEPTS of renal pathology have been lacking because renal disease frequently does not become fatal until the anatomy is too distorted to distinguish one disease from another. Due to the kidney's limited ways of clinical expression of various diseases, much inaccurate knowledge has been recorded from clinical impressions. Percutaneous biopsy of the kidney, particularly in conjunction with electron microscopic studies, has added extensively to our knowledge in the last few years. Ciba, as usual, has gathered many of the world's foremost experts in this field to discuss this subject under the chairmanship of the great Dr. Arnold Rich. Indications for percutaneous biopsy pointed out by the participants are, (1) Choice of treatment in the nephrotic syndrome, (2) Need to determine whether or not to repeat dialysis in anuria, (3) Differential diagnosis in chronic nephritides such as the familial type, oxalosis, nephrocalcinosis, etc., (4) Persistent proteinuria, (5) Recurrent hematuria, (6) In the diagnosis chronic pyelonephritis, (7) Secondary amyloidosis, (8) Disseminated lupus, (9) Primary aldosteronism, (10) Selection of patients for nephrectomy, (11) Study of the opposite kidney in unilateral renal ischemia.

No deaths were recorded by this group in over 5000 biopsies. Four nephrectomies had to be performed because of bleeding.

This book will be valued by all urologists, pathologists and by all internists with a special interest in renal disease.

Arthur J. Merrill, M.D.

ARIEL, Felix Marti-Ibanez, M.D., MD Publications, Inc., New York, 1962.

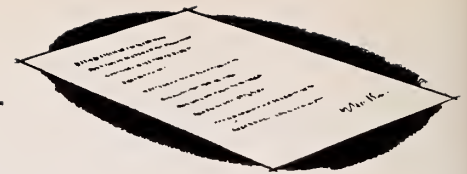
"A LIFE CULTURALLY ENRICHED is the best way to attain ataraxia." Self-control and presence of mind in any emergency are two qualities that mark the happy physician. Dr. Marti-Ibanez has done much to help the American physician achieve this 'calm alertness and happiness of soul' of the ancients by making available in a monthly 'throw-away' MD (a monthly medical news magazine) much of what is great in medicine and the arts. In this, *Ariel*, his latest collection of essays, he has expanded some of the MD contributions, but more than this he has given the busy physician a handy desk companion of less than 300 pages of which each page is a sparkling jewel. Open to any chapter—any page—in the middle of a busy day and find for five or ten minutes a respite from the ordeal and demands associated with daily medical practice. In five minutes one can learn the meaning of the symbol Rx, of the significance of the Centaur, and the origins of the Caduceus.

In less than ten minutes of flight into ataraxic space, the tense physician can become lost in the short chapter, "No Books On The Ferry From Hong Kong." Dr. Marti describes the ten books which he would most like to take on a vacation.

The formal scientific education of the physician usually denies him an opportunity to become acquainted with the world's great literature. His unilateral training has often failed to introduce him to the daring, restless, adventure-seeking men and women of the romantic novels which appeal to Dr. Marti. The good doctor whets the appetite by his suggestions for good reading. Should the history of the background of antibiotics be unknown to the reader, the chapter, "The First Thirty Years," weaves the story of scientific philosophy, expertly coupled with the romanticism of the subject, into a tapestry that adds life to an otherwise dull, laboratory experience. "Man is not only nature but history. Man is what he does, the succession of moments in his life, his passage on a spatial form through time, a form always subject to the forces of his genetic equation, his environment, his internal stresses, and his free will, all of which create his biography, of which disease is a part."

There is not a sterile chapter in these 300 pages. There is not a chapter which will fail to affect the physician's psyche, for such words have seldom flowed from the mind of a physician onto the printed page and been made available in such an attractive fashion.

Peter L. Scardino, M.D.



Dowman, Charles E., M.D., 1415 Peachtree Street, N.E., Atlanta 9, Georgia, "Midline Spinal Anomalies in Infants and Children," South. M. J. 55:439-444 (May) 62.

Most midline spinal anomalies are present at birth and easily recognizable, if one will but look, and can be helped by neurosurgical efforts. The effect of others can be ameliorated by a sensible approach to the problem. Recognition of such lesions by the obstetrician or the pediatrician immediately after birth will make possible the institution of early neurosurgical therapy and thereby reduce the morbidity for these poor children.

Tiny congenital dermal sinuses are frequently overlooked. These are liable to infection until the defect is closed with good skin. Elective closure is much better than emergency efforts after meningitis has occurred. Some meningoceleceles can be helped by surgical efforts while others can be treated only with nursing care. Entire bony segments may be missing with nervous and muscular segments also being absent. Sacral lipomas and teratomas usually require early treatment of a surgical nature. Diastematomyelic problems can be recognized by progressive paraparesis providing the entire spine is x-rayed, inasmuch as the canal is widened at such levels.

Where the skin is poor, better protection from infection with good skin, as soon as mechanically feasible, is recommended.

Wood, J. Edwin, M.D., and Battey, Lewis L., M.D., Medical College of Georgia, Augusta, Georgia, "The Natural History of Diastolic Hypertension and the Effects of Blood Pressure Regulation," Am. J. of Cardiol. 9:675-679 (May) 62.

Currently available information indicates that essential hypertension is a heritable disorder. The rise in blood pressure first appears in middle years and is associated with minor symptoms apparently related to the direct physical effect of the elevated blood pressure. The complications of heritable hypertension and the large numbers of patients that are affected by this disorder are the reasons for the great medical importance of this disease. Prolonged excessive arterial pressure accelerates the development of atherosclerosis. These patients are subject to strokes, coronary artery disease, and renal damage. Excessive resistance to blood flow eventually leads to left ventricular failure. Life insurance statistical studies of patients with mild elevation of diastolic pressure indicate that their longevity is reduced, thus raising serious doubt as to the propriety of the term "benign hypertension." Malignant hypertension is a complication of essential hypertension that may occur. Young patients

(average age 41 years) are subject to this sudden acceleration of the disease process. It is characterized by papilledema and retinopathy, fixed excessive diastolic blood pressure, and rapidly advancing uremia. Evidence relative to the effectiveness of therapy supports more strongly than ever the hypothesis that morbidity and mortality of all hypertensive patients is reduced by medical therapy.

Maner, F. Debele, M.D.; Saffan, Benjamin D., M.D.; and Preedy, John R. K., M.D., Emory University (Department of Medicine), Atlanta 22, Georgia, "Effect of Purified Ovine Pituitary Follicle-Stimulating Hormone (NIH-FSH-S-1) on the Urinary Estrogen Output of Normal Menstruating Women," Clin. Endo. & Metab. 22:525-531 (May) 62.

The effect of administering the purified ovine pituitary follicle-stimulating hormone preparation (NIH-FSH-S-1) on the urinary excretion of estrogens was studied in ten normal menstruating women, five in the proliferative phase and five in the secretory phase of the cycle. During the proliferative phase, a significant increase in urinary estrogens was observed in three of the five cases. In the remaining two cases, no significant rise occurred, and in these cases there was a significant depression below the expected values after the discontinuance of FSH. Similar results were obtained during the secretory phase. Therefore, this FSH preparation could be considered to be active in the human, in terms of alterations (increase or decrease) in the urinary estrogen output. In those cases in which the urinary estrogen output was decreased, the exogenous FSH may have caused an unphysiologic alteration in the LSH:LH ratio, with possible suppression of ovarian estrogen production. Significant antihormone formation was considered to be unlikely.

Greenblatt, Robert B., M.D., and Rose, Fred, M.D., Medical College of Georgia, Augusta, Georgia, "Delay of Menses: Test of Progestational Efficacy in Induction of Pseudopregnancy," J. Obst. & Gynec. 19:730-735 (June) 62.

The introduction, in recent years, of numerous progestational compounds for clinical use has highlighted the need for a simple clinical test to determine their efficacy. The true potency of any progestational agent may be assayed by the amount needed (along with a standard dose of estrogen) to prevent the onset of menses for a fixed period, such as 14 days after the expected menstruation. Thus, with normal ovulatory women, the agents to be tested are administered from day 20 (or about six days after ovulation) for 20 days so that the menses is delayed to about

day 42, thus simulating the action of the corpus luteum of pregnancy. Attempts to delay menstruation to a prolonged cycle of 42 days with moderately high doses of estrogens alone were uniformly unsuccessful. By trial and error we found that 0.1-0.2 mg. of ethinyl estradiol 3 methyl ether (EE3ME) or its equivalent, was the basic dose necessary to complement the action of oral progestational agents for the test. Norlutin and Enovid were successfully employed in 15 mg. doses. Chlormadinone (6-chloro-6-dehydro-170-acetoxypregnosterone) one of the newer progestins, proved to be one of the most potent thus far employed. It was found that 4-6 mg. of chlormadinone with 0.12-0.18 mg. of EE3ME was adequate for a positive delay of menstruation test in almost every instance. The amount of estrogen and progestational agents needed for this test could serve as a guide to the requirements for induction of pseudopregnancy in the management of endometriosis.

Hargrove, Marion D., Jr., M.D., Shreveport, La.; Galambos, John T., M.D.; and Raaen, Tom D., M.D., Emory Hospital, Atlanta 22, Georgia, "Relationship Between Alcoholism and Morphogenesis of Cirrhosis," South. M. J. 55:483-487 (May) 62.

In this sample, portal cirrhosis was equally as common in males as in females, but post-necrotic cirrhosis was twice as common in males as in females.

Cirrhosis is more common in the white population than in the Negro population studied.

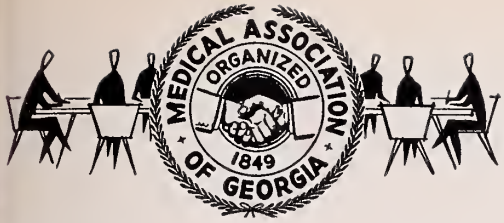
Alcoholism is common among cirrhotics regardless of its morphologic classification. More than one-half of the patients with post-necrotic cirrhosis were alcoholics. Of the 39 alcoholic patients, 17 had post-necrotic cirrhosis and 22 had portal cirrhosis.

There was no significant difference in the distribution in the two types of cirrhosis and the sex of the patients.

Alcoholics tend to manifest post-necrotic cirrhosis or portal cirrhosis at an earlier age than do non-alcoholics.

d'Amato, Gabriel, M.D., Eugene Talmadge Memorial Hospital, Augusta, Georgia, "Chlordiazepoxide in Management of School Phobia," Dis. Ner. Sys. 23:292-295 (May) 62.

A directive treatment of children with school phobia is described. Rapid treatment and early return to school seem to be facilitated by (a) management of the child, parents, and school by one coordinating physician, (b) the use of a drug (chlordiazepoxide) reportedly effective in phobicobsessive states.



THE ASSOCIATION

DEATHS

THOMAS NORMAN FREEMAN, JR., 45, a native of LaGrange, died June 3, 1962, at his office in LaGrange.

Dr. Freeman received his medical degree from the University of Georgia in 1940 and served his internship at Georgia Baptist Hospital, Atlanta. He was a member of the Troup County Medical Association, the Medical Association of Georgia, the American Medical Association, and the First Baptist Church of LaGrange.

He is survived by his wife, Katherine Krafka Freeman; two daughters, Mary and Katherine Freeman; three sons, Tommy, Jack, and Joe Freeman; his mother, Mrs. T. N. Freeman, Sr.; four sisters, Dr. Bernice Freeman, LaGrange; Mrs. Preston A. Sipes, Washington, D. C.; Mrs. W. E. Cornater, Grand Forks, N. D.; Mrs. James M. Hunter, Atlanta; and one brother, Lorimer B. Freeman, Dahlonega.

MARION TROTTI BENSON, Atlanta obstetrician, died in an Atlanta Hospital June 7, 1962. Dr. Benson suffered a stroke June 3, 1962, upon learning of the death of his wife, Sarah Latimer Clay Benson, in the Paris plane crash of June 3. A native Atlantan, Dr. Benson graduated from Emory University School of Medicine and interned at Grady Memorial Hospital.

He was a communicant at the Cathedral of St. Philip and was a member of the American College of Obstetricians, the Medical Association of Georgia, the Fulton County Medical Society, the Piedmont Driving Club, and the Nine O'Clocks.

Dr. Benson is survived by a stepdaughter, Mrs. James M. Vance, St. Louis, Missouri; a stepson, Stephens Clay, Atlanta; and three brothers, Dr. Henry Bagley Benson and Lawrence Walker Benson, Atlanta; and Dr. Charles C. Benson, Belmont, Mass.

ANDREW JACKSON JONES, 82, of Telfair County died June 2, 1962, in the Telfair County Hospital after a brief illness. Dr. Jones, a native of the county, had been practicing there since 1911.

A member of the Blockhouse Baptist Church, he graduated from the Atlanta Medical College.

Survivors include five sons, Emory, Ernest, Leslie, and Lawson Jones of Jacksonville; and Julian Jones of Warner-Robins; one brother, C. W. Jones, McRae; and a number of grandchildren and great-grandchildren.

SOCIETIES

CARROLL-DOUGLAS HARALSON MEDICAL SOCIETY met June 4, 1962, at Carrollton. The program was presented by Dr. R. L. Johnson, Douglas, and Dr. J. I. Van Sant, Villa Rica, who attended the MAG convention as delegates. A short scientific program presented by Dr. Robert L. Berry of Villa Rica followed.

GEORGIA MEDICAL SOCIETY met June 12, 1962, at Savannah. Presenting a color movie on Savannah was the Chamber of Commerce.

RICHMOND COUNTY MEDICAL SOCIETY met June 6, 1962, at Augusta. Dr. F. N. Harrison of Augusta, society and board president, reported that the board had voted unanimously to support the proposed \$12.5 million University Hospital.

SOUTHEAST GEORGIA MEDICAL SOCIETY met May 16, 1962, at Vidalia, to adopt a resolution concerning fluoridation of the water supply for the counties of Toombs, Tattnall, Treulen, Wheeler, and Montgomery.

WHITFIELD-MURRAY COUNTY MEDICAL SOCIETY met June 7 and 8, 1962, at Dalton. The society sponsored a special two-day seminar offering demonstrations and instruction in several fields of medicine. The seminar, developed and conducted by the Department of Continuing Education of the Medical College of Georgia, featured members of the college faculty who held discussions dealing with the diagnosis and treatment of specific health problems.

PERSONALS

First District

No news submitted.

Second District

PAUL LUCAS was the speaker at the June 6, 1962, meeting of the Tifton Rotary Club. Dr. Lucas' topic dealt with the scientific developments now being used in the medical field in connection with space exploration.

Four Thomasville doctors have been named as officers of the Thomas County Blood Program for 1962-1963. FRED MURPHY has been named chairman succeeding CHARLES H. WATT, JR., who will become the new vice-chairman, and FRANK LITTLE and WARREN TAYLOR are chairman and vice-chairman, respectively, of the program medical staff.

Faculty members of the Medical College of Georgia at Augusta, JOHN W. KEMBLE, JAMES R. TEABEAUT, II, and ROY WITHERINTON, participated in a one-day medical seminar sponsored by the college and held at the VA Domiciliary at Thomasville on June 14, 1962. Other area doctors attending were RUDOLPH BELL, JULIAN B. NEEL, J. I. PALMER, ROY F. STINSON, and ALBERTO A. ZAVELTA, all

of Thomasville, and J. G. CROVATT, Dublin; JAMES T. FLYNN, Moultrie; J. C. BRIM, Pelham; and A. F. SAUNDERS, Valdosta.

Third District

W. G. TALBERT, JR., of Warner-Robins has been re-elected as chief of the medical staff of Houston Hospital. Re-elected to serve with Dr. Talbert were M. V. ANDERS, vice-president, and ROBERT A. CARTER, secretary, also of Warner-Robins.

Associated with WILLIAM H. BRIDGES of Dawson in the general practice of medicine will be CHARLES A. SHEFFIELD of Colquitt.

201 Randolph Street, Cuthbert, is the new location of the offices of W. G. ELLIOTT and R. B. MARTIN, III, Cuthbert, and C. E. SILLS, Plains.

Fourth District

T. A. SAPPINTON, Thomaston, has announced the plan to have Upson County Hospital's first intern this summer. The intern will be a senior medical student from the Medical College of Georgia at Augusta.

The Covington Kiwanis Club had as its June speaker, FRANK WALKER of Atlanta. Dr. Walker, Consultant Radiologist at Newton County Hospital, is Speaker of the House of Delegates of the American Medical Association of Georgia.

"The Three Keys to a Happy Marriage" was the topic of a talk given by ERNEST A DUNBAR, Forest Park, at the June 4, 1962, meeting of the Forest Park Kiwanis Club.

Fifth District

CHARLES T. BROWN, Guyton, Director of Public Health, District Seven, has accepted the position of Medical Director of the Branch of Special Services, Chronic Disease and Geriatrics, State Health Department, Atlanta, Georgia. Dr. Brown assumed his duties July 1, 1962.

J. GRANT WILMER of Atlanta, spoke to the Rockmart Kiwanians, June 11, 1962, at a program sponsored by the Georgia and the American Heart Associations.

JAMES Z. SHANKS, Atlanta, is now associated with ROBERT C. DAVIS, Atlanta, in the practice of internal medicine.

The National Foundation has chosen WILLIAM G. THURMAN, Assistant Professor of Pediatrics at Emory University Hospital, as the director of its program for the study of birth defects. The program will be centered at Emory University, which received a large grant for the studies.

A year's grant of \$33,172 from the U. S. Army's Research and Development Command has gone to MILTON F. BRYANT, Atlanta, for further research at Piedmont Hospital's Ferst Laboratory. Dr. Bryant has acted as chief investigator for research which may lead to the prevention of clots in blood vessels.

Sixth District

Z. SWEENEY SIKES, Macon, moved in July to his new offices at 803 Spring Street, Macon.

W. DEVEREAUX JARRATT and R. JAMES HOOPER, Macon, have announced the association of HOMER S. NELSON in the practice of ophthalmology at Macon.

J. G. BRANTLEY of Wrightsville has received the 50 year certificate from the Medical Association of Georgia, June 1, 1962, for completing 50 years of general practice of medicine in his home town and county.

Seventh District

A film on heart disease and heart surgery was shown by WILLIAM A. HOPKINS, Atlanta, to the Echota-Vann Shrine Club at their meeting June 21, 1962, at Calhoun.

THOMAS H. CURTIS, Ft. Oglethorpe, passed the American Board Examination in Obstetrics and Gynecology in June.

A new Doctors Building to be opened in August at Cartersville will have offices for H. B. BRADFORD, W. B. DILLARD, JR., W. H. HOWELL, W. B. QUILLIAN, JR., THOMAS HAMILTON, and ROBERT MAY.

LEE J. KNIGHT, in June, joined HOWARD M. SIGAL, Smyrna, for the practice of pediatrics in the Cherokee Medical Building at Smyrna.

VIRGINIA HAMILTON, Cartersville, is the district director of the new Katherine Dorsey Health Center opened June 10, 1962, at Cartersville.

Eighth District

The King-Anderson Bill was the topic of a talk given by J. W. YEOMANS, Jesup, at the Jesup Rotary Club meeting held June 14, 1962.

Ninth District

Honored on June 22, 1962, in Blairsville for the contribution he has made to good citizenship while practicing medicine in the city, was CHARLES LITTLE. Dr. Little, presented with a monetary gift, began work in June in orthopedic surgery at Grady Memorial Hospital, Atlanta.

Groundbreaking ceremonies for the new Woodstock Medical Center were conducted June 9, 1962, by T. J. VANSANT, SR., Woodstock.

Toccoa Clinic Medical Associates announced July 1, 1962, the association of ELTON L. COPELAN, in the practice of obstetrics and gynecology. Dr. Copelan formerly resided in Atlanta.

Tenth District

WILLIAM E. BARFIELD, Augusta, was one of the physicians recently inducted as a Fellow of the American College of Obstetricians and Gynecologists.

CHARLES FREEMAN, SR., Augusta, spoke to the PBX Club of Augusta on June 12, 1962. Dr. Freeman's talk concerned the King-Anderson Bill.

JOHN E. POLLOCK, JR., Washington, entered the practice of medicine, July 1, 1962, at which time he became associated with CHARLES WILLS and M. C. ADAIR, Washington.

Visiting lecturers at the Refresher Symposium in General Medicine held June 7 and 8, 1962, at Hamilton Memorial Hospital in Dalton were ARTHUR B. CHANDLER, JAMES B. HUDSON, WILLIAM E. LAUPUS, and FREDERICK ZUSPAN, all of Augusta.

JULIUS T. JOHNSON, Augusta, has announced the opening of his office in the practice of psychiatry and neurology in association with J. KENNETH McDONALD, Augusta.

Assuming duties on July 2, 1962, as the Director of Public Health, District 24, was STEPHENS BYARS, Monroe. Dr. Byars and his family will move to La-Grange in the near future.

MEDICAL ASSOCIATION OF GEORGIA COUNCIL MEETING

2:00 P.M.
June 16, 1962

Holiday Inn,
Augusta, Georgia

THE COUNCIL MEETING was called to order by Chairman George H. Alexander on June 16, 1962, at 2:20 P.M., at the Holiday Inn, Augusta, Georgia.

Members of Council present were: Thomas W. Goodwin, Augusta; George R. Dillinger, Thomasville; Fred H. Simonton, Chickamauga; Lee H. Battle, Rome; Walker L. Curtis, College Park; George H. Alexander, Forsyth; John T. Mauldin, Atlanta; John S. Atwater, Atlanta; J. Frank Walker, Atlanta; Joseph B. Mercer, Brunswick; Charles Bohler, Brooklet; Frank Wilson, Leslie; Virgil Williams, Griffin; Floyd Sanders, Decatur; William Rawlings, Sandersville; Ralph N. Johnson, Rome; F. G. Eldridge, Valdosta; C. R. Andrews, Canton; Addison Simpson, Jr., Washington; Walter Brown, Savannah; H. D. Pinson, Augusta; J. G. McDaniel, Atlanta; J. L. Mulherin, Augusta; Luther Wolff, Columbus; W. H. M. Weaver, Macon; Charles S. Jones, Atlanta; Eustace A. Allen, Atlanta; and Henry H. Tift, Macon. Visiting physicians from Augusta were: Preston Ellington, Curtis Carter, Walter Sheppard, F. N. Harrison and Harry O'Rear. Also present were Mr. John Moore, MAG attorney; Mr. Richard Nelson, AMA Field Representative; Mr. M. D. Krueger and Mrs. Catherine Wooten, MAG Staff.

The invocation was given by Dr. Goodwin.

Reading of Minutes

After the review of the minutes of May 5 and 9 Council meetings and May 9 and 21 Executive Committee meetings, the minutes were approved as read.

Introduction of New Councilors

Chairman Alexander recognized new members of Council who were attending for the first time.

Treasurer's Report

Treasurer Atwater gave the Treasurer's Report and on motion duly made and seconded it was approved as given.

After information from Secretary Atwater regarding a deficit in the postage and copyright fund, on motion duly made and seconded, it was voted to approve the transfer of \$100.00 from the Contingent Fund to make up the deficit in the postage and copyright fund.

Certificate of Appreciation to Vice Councilors

In behalf of Executive Committee, Secretary Mauldin asked Council's opinion as to whether Vice Councilors should be awarded Certificates of Appreciation upon termination of office. On motion (Simonton-Bohler) it was voted that Certificates of Appreciation be given to Vice Councilors on the basis of individual consideration by Executive Committee.

Confirmation of Executive Committee Board and Sub-committee Recommended Appointments

President Goodwin read the Executive Committee recommended appointments to the MAG Boards and Sub-Committees. On motion duly made and seconded it was voted to approve these appointments.

McLoughlin Resolution

Councilor Paul Scoggins recommended that a committee be appointed to draw up a Resolution on the death of Dr. Christopher J. McLoughlin in the Paris plane crash of June 3, with the Resolution to be sent to the family of Dr. and Mrs. McLoughlin. This recommendation was approved on motion duly made and seconded. Chairman Alexander then appointed Virgil Williams, Paul Scoggins and F. G. Eldridge to write this Resolution and present it at the Sunday Council meeting.

Blue Shield Senior Citizens Plan

President Goodwin discussed the difference of opinion regarding the disposition of this problem at the MAG House of Delegates meeting in Savannah. He read a letter from Dr. Hilt Hammett expressing the opinion of the Board of Directors of the Columbus Blue Shield Plan, and which enclosed 26 petitions signed by the required number of delegates to hold a special session of the MAG House of Delegates. After lengthy discussion, on motion (Mercer-Atwater) it was voted that the request for the special session be put into the hands of the Executive Committee to handle with the writers of the petition and that if this matter could not be satisfactorily resolved with the petitioners, that the Executive Committee must call a special session of the House of Delegates within 45 days from this date (June 16). Council recommended that Executive Committee action be postponed until after the AMA June 24 meeting in order to obtain more information and because the majority of the Executive Committee would be at the AMA meeting.

1962 Annual Session Financial Report

Mr. Krueger read the Annual Session financial report. On motion duly made and seconded it was voted to write Dr. Hydrick and commend him for his work on the Annual Session. Mr. Krueger asked Council's opinion regarding the payment of the expenses of a guest speaker at the 1962 Annual Session. These expenses were more than the specialty society had planned to spend. It was Dr. Hydrick's recommendation that the specialty society make every effort to pay their commitment. On motion duly made and seconded it was voted that MAG underwrite Dr. Creevy's expenses and call upon the Georgia Urological Society to reimburse the MAG for the amount paid by MAG.

Ad Volorem Property Taxes

Dr. McDaniel discussed the tax status of the MAG. No definite decision had been made according to his report.

Headquarters Office Report

Mr. Krueger discussed the resignation of Medicare Administrator, Mr. Frantz Lipsey, and the employment of Mr. James Baker to fill this position. He informed Council of the employment of a new Managing Editor of *JMAG*. He also mentioned the program of the forthcoming AMA meeting in Chicago.

The meeting was recessed at 4:30 P.M.

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The June 17 meeting of Council was reconvened at 8:28 A.M. by Chairman Alexander.

Southeastern States Hospitality Suite, AMA Meeting, June 24, Chicago

Dr. Allen informed Council that it was the opinion of some of the AMA delegates from the Southeastern states that a hospitality room of the S.E. states would be of more benefit than for each state to have a separate hospitality room. Secretary Mauldin explained that \$400.00 had been set aside for this purpose, but this would not be adequate if the S.E. States Hospitality Suite was approved. On motion duly made and seconded it was voted to take this additional \$300.00 from the Contingent Fund for the S.E. States Hospitality Suite at the AMA meeting.

1962 MAG House of Delegates Actions

Speaker of the House Walker asked Council's approval on the suggested list of House of Delegates actions which he read. The actions were discussed and Council took action on the following, which were referred to this body:

(a) Secretary's Report: Suggested purchase of stove and sink for the MAG Headquarters Building to facilitate the serving of lunches. On motion duly made and seconded Council approved the expenditure of funds for the purchase of a stove and sink for the Headquarters building and authorized Executive Committee to act on this at the proper time.

(b) AMA Delegates' Report: Suggested Council consideration of meeting the expenses of both the Delegates and Alternate Delegates to AMA. On motion duly made and seconded it was voted that this matter be referred to the Executive Committee and Finance Committee with the idea in mind of including the expenses of Alternate Delegates in the budget next year in the amount of \$250.00 for each AMA meeting per year.

Upon completion of the report by Speaker Walker it was voted to approve the entire report as presented.

Legislative Report

Dr. Walker reported on the Legislative Board's activities since the last Council meeting regarding mailings, personal contacts and the recent Washington trip. Mr. Nelson made a few remarks regarding the effectiveness of this trip and congratulated the MAG in behalf of the AMA. Dr. Walker reviewed the Board's expenses and asked for an additional \$700.00 for the remainder of the year. On motion duly made and seconded it was voted to take the \$700.00 from the Contingent Fund for the Legislative Board.

Eugenic sterilization was discussed by Mr. John Moore, MAG Attorney. The State Health Department would like to have the sterilization law repealed and has asked the MAG to render an opinion. After discussion, on motion duly made and seconded, it was voted to refer this matter to the Sub-Committee on Maternal and Infant Welfare for study and report back to the Board of Legislation for subsequent report to Council at the September meeting.

AMA Board of Trustees Report

Dr. Allen's report was received for information.

McLoughlin Resolution

Dr. Williams, as Chairman of the committee appointed by Chairman Alexander to draw up a Resolution, read the Resolution. On motion (Goodwin-Mauldin) it was voted to approve the Resolution and send a copy to Dr. McLoughlin's family and to incorporate the Resolution in the minutes of Council.

RESOLUTION

"WHEREAS, the life of Christopher J. McLoughlin was marked by years of service as a member of the Medical Association of Georgia, having served as an officer he contributed much to the advancement of the organization. His devotion and dedication to his profession and fellowman was felt by all who knew and loved him. The Medical Association of Georgia is better for his having been our friend and one of us. His name and way of life have given an added luster to his profession and the world in which he lived.

BE IT RESOLVED, that the untimely and grievous loss of Christopher J. McLoughlin the Medical Association of Georgia extends its most profound sympathy and condolences to his family and loved ones and joins those who enshrine the memory of him in their hearts."

Unfinished Business

Dr. Mercer discussed further the Blue Shield Senior Citizens Plan, which was discussed at the Saturday (June 16) Council meeting. He read a Resolution as follows:

RESOLUTION

"WHEREAS, the Council of the Medical Association of Georgia, speaks for the Doctors of Georgia in their desire to see that all of our Senior Citizens receive adequate medical attention, and

WHEREAS, the House of Delegates of the Medical Association of Georgia in official session, did, by majority vote, table the question of complete MAG endorsement of the proposed Blue Shield Senior Citizens Plan, and

WHEREAS, the State of Georgia is somewhat unique in having their separate Blue Shield Plans serving three specific geographic areas within this state, and

WHEREAS, each Blue Shield Plan has developed contracts distinctly different in nature and which, therefore, present problems peculiar to each geographic area.

NOW, THEREFORE, BE IT RESOLVED that the Council of the MAG takes the official stand that though it has the legal right, it does not have the moral right to take action on the question for the State as a whole in view of the divided opinions in the House of Delegates, and

BE IT RESOLVED that this Council recognizes the varied problems according to geographic area, and

BE IT RESOLVED that Council approves and endorses the Senior Citizens Blue Shield Contract in those geographic areas where the majority of physicians subscribe to the service concept, and

BE IT FURTHER RESOLVED that the Council of MAG recognizes the unqualified right of physicians in those areas served by other Blue Shield Plans, and of individual physicians in any area of the state, to reject participation on a Service Basis in such Senior Citizens Blue Shield contracts."

Dr. Mercer proposed the adoption of this Resolution to obviate the need for the special session of the House of Delegates. On motion duly made and seconded it was voted to approve the Resolution as written.

Chairman Alexander thanked the President and members of Council from Richmond County Medical Society for the hospitality at this Council meeting. On motion duly made and seconded Council gave a rising vote of thanks to these members of Council.

New Business

(a) A plan to meet the need for training additional medical students by utilizing private hospitals was discussed. Dr. Allen had been given a plan written by Dr. Walter Bloom to be presented before the AMA House of Delegates. On motion (Mauldin-Mercer) it was voted to refer this matter to the AMA delegates to make a decision on the matter. Another motion duly made and seconded voted to refer the matter to

the MAG Board on Medical Education for further study and report to Council at a future date.

(b) Dr. Simonton reported on the All Faiths Chapel at Milledgeville and a Congressional Record item on elimination of personal income tax.

(c) Letter from the President of SAMA chapter at the Medical College of Georgia was read by Secretary Mauldin, expressing appreciation for the financial aid which made possible the attendance of three representatives at the national SAMA convention.

(d) Letter from Mr. and Mrs. James M. Moffett was read by Secretary Mauldin in which they expressed appreciation for flowers sent at the time of Mr. Moffett's mother's death.

(e) State Medical Education Board discussion about training for psychiatrists.

(f) Date and site of September Council meeting: On motion duly made and seconded it was voted to hold the September Council meeting after the Georgia Heart Association meeting on Jekyll Island.

There being no further business, the meeting was adjourned at 10:40 A.M.

EXECUTIVE COMMITTEE OF COUNCIL

Reading of Minutes

10:00 A.M.

June 16, 1962

Holiday Inn,
Augusta, Georgia

THE EXECUTIVE COMMITTEE of Council meeting was called to order by the Chairman, Thomas W. Goodwin, at 10:20 A.M., June 16, 1962, at the Holiday Inn, Augusta, Georgia.

The members in attendance were Thomas W. Goodwin, Augusta; George R. Dillinger, Thomasville; Fred H. Simonton, Chickamauga; J. G. McDaniel, Atlanta; John T. Mauldin, Atlanta; George H. Alexander, Forsyth; and Lee H. Battle, Rome. Also present were Virgil Williams, Griffin; Mr. Richard Nelson, AMA Field Service Staff; and Mr. Milton D. Krueger and Mrs. Catherine Wooten, of the MAG Headquarters Staff.

Reading of Minutes

Mr. Krueger read the minutes of the May 9 and 21 Executive Committee meetings. On motion duly made and seconded the minutes were approved as read.

Appointment of Representatives to Board of Directors of Allied Medical Careers Clubs

Secretary Mauldin read a letter from the Allied Medical Careers Clubs requesting appointment of a representative to their Board of Directors. After discussion and by general agreement, it was decided to appoint Frederick A. Carpenter, Atlanta.

MAG Board and Sub-committee Appointments

The Executive Committee considered Board and Sub-Committee appointments and after deliberation made the required appointments. Attached is a list of 1962-63 Board and Committee Appointments as later approved by MAG Council. See reverse of contents page.

On motion duly made and seconded it was voted to refer to the Constitution and Bylaws Committee for clarification, the Medical Defense Committee status.

On motion duly made and seconded it was voted to accept the appointment of the Woman's Advisory Committee as the President had chosen and omit the dates of office.

State of Georgia Hospital Advisory Council for Construction, Licensure, and Indigent Care Appointment to fill expired term of W. L. Pomeroy, Waycross—The Executive Committee appointed Samuel U. Braly, of Dallas.

Sub-Committee on Public Health: On motion duly made and seconded it was voted as a recommendation that the names of the members of this sub-committee be added to the list of those invited to the State Board of Health meetings. It was suggested by Dr. Simonton that this sub-committee, the MAG Executive Committee, and the State Board of Health Executive Board meet to review the new recodification of the Public Health Laws. The meeting will be held August 16, 1962, in Augusta, and a notice will be sent out to this effect. The Executive Committee agreed to this suggestion.

Workmen's Compensation Fee Schedule

Secretary Mauldin read a letter and then discussed the appointment of Allen M. Collinsworth, Atlanta, to the Sub-Committee on Industrial Health. The Executive Committee agreed to this appointment and it was so recorded.

MAG Employees Pension Plan

Deferred.

Headquarters Office Report

Mr. Krueger informed the Executive Committee of the resignation of the Medicare Director Frantz Lipsey and the employment of James Baker to this position. He also stated a Managing Editor for the *JMAG* had been employed and would report for work on June 18, 1962.

New Business

Date and Site of July Executive Committee meeting: July 18, 3:30 P.M., MAG Headquarters Building.

There being no further business, the meeting was adjourned at 1:05 P.M.

PHYSICIANS CONTRIBUTE FOUR MILLION TO NATION'S MEDICAL SCHOOLS

American physicians contributed more than \$4,700,000 to the nation's medical schools last year, the American Medical Association has announced.

The AMA said physicians gave \$1,303,161.00 through its Education and Research Foundation and \$3,428,413.09 in direct contributions to the schools, for a grand total of \$4,731,574.19.

Money given directly to the medical schools came from 55,688 physician contributors across the country.

The AMA said that since its Foundation was established in 1951, physicians have donated more than \$11,500,000 through it. Money contributed to the Foundation may be designated for a specific medical school.

Contributions not designated are divided equally among the country's 86 schools.

Deans of the schools may use Foundation grants at their discretion for special projects or expenses outside of their budgets.

The AMA established the Foundation so that physicians could play a greater part in financial support of the nation's medical schools. Every dollar contributed goes to the medical schools, since operating costs are assumed by the AMA.

Of the total contributions made through the Foundation last year, \$202,219.27 was raised by the Woman's Auxiliary to the AMA.

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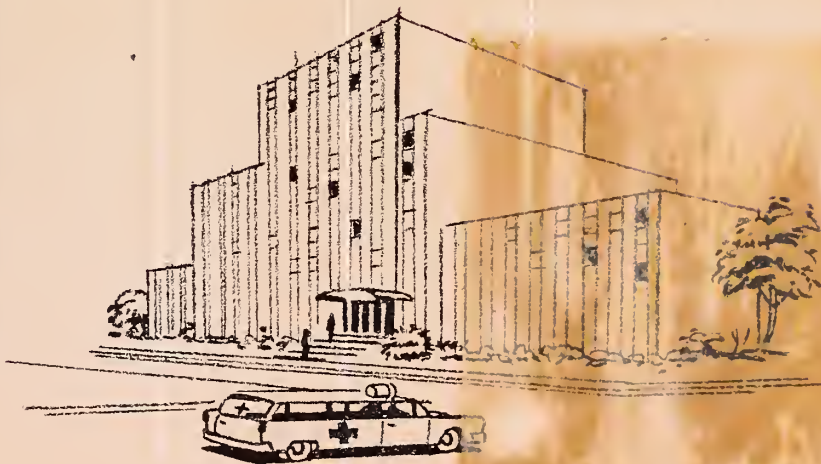
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See: Page 452

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Georgia Kerr-Mills Program Expands—
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Special Article

MEDICAL-LEGAL LEGISLATION AS A PUBLIC SERVICE

Honorable Robert H. Hall, *Atlanta**

TO BE A DOCTOR or lawyer today carries with it a more than usual responsibility to the public interest. Our two professions are dedicated to a spirit of public service. Physicians and lawyers offer certain services, and they perform with the same diligence and quality of service whether they are paid or not. The physician or lawyer does not patent his discoveries or exploit them for his own personal gain, but makes them known to the profession and to the public. He practices preventive medicine and law. He does not seek to create a demand for his services in the fashion that the businessman does. Dean Roscoe Pound has said that a profession is "A group of men pursuing a learned art... in the spirit of public service."

The words "medical" and "legal" both refer to certain common callings of a traditionally dignified character, i.e., learned professions. They developed during the Middle Ages along with the rise of the universities. Physicians and lawyers received prolonged formal training, and after they had completed their training, they constituted a class apart.

These two professions in their early beginnings were organized like guilds. Now they have a broader function, and through their associations they have established codes of ethics. The associations exist primarily for the advancement of medicine and justice, not for the individual members, as in the case of trade unions.

Let us consider the responsibilities that are owed by our professions to society.

Naturally, as members, we have the duties common to citizens as a whole: To vote, to support our churches and institutions, to pay taxes, to participate in community activities. Yes, to offer for public office when the need arises.

However, aside from these, we have another responsibility, more or less peculiar to physicians and lawyers. It is the duty to supply intelligent, unselfish leadership to the forming of public opinion in the influencing of important issues.

Democracy requires leaders, not in the authoritarian sense of having the power of command, but in the sense of being able to persuade others to follow.

Physicians and lawyers are needed for democratic leadership. The calming influence that they can supply is a powerful security against excesses of power, from any quarter, and affords the stability which every well-ordered society requires.

The Bible says, "Every one to whom much is given, of him will much be required: and of him to whom men commit much they will demand the more."

I can think of no better use or greater need for this kind of leadership than in the field of legislation—the enactment of laws which will govern our society.

Legislation is public policy and governs public administration. Ofttimes, now, a simple act, or a short constitutional provision of even a few words, properly projected into actual operation, has a far-reaching impact upon the public good.

The most notable contribution to public adminis-

* Judge, Court of Appeals of Georgia; former Professor of Law, Emory University and former Assistant Attorney General of Georgia. An address delivered at the December 1961 meeting of the Brooks-Thomas County Medical Society, Thomasville, Georgia. Introductory remarks are omitted.

tration in Georgia by the medical profession, perhaps in the past 100 years, was that made through the professional committee appointed by Governor Ernest Vandiver to study and make recommendations for an immediate and a long-range mental health reform program in Georgia.

The report, nonpolitical in nature and exceedingly fair in scope and content, has set off revolutionary improvements in that field, the benefits of which will multiply many fold over the years and restore lives and productivity.

Here was an instance of the public conscience remembering the forgotten man. Here was an instance of the public conscience demanding that the rug of neglect be lifted, that the filth of complacency be swept away, that finally the light of treatment and rehabilitation would shed its rays into the dark corners, and that no longer would snakepit conditions blot the reputation of our state.

The effort to do something about this was not easy.

It was expensive.

It was time-consuming.

Professional men were called away from their patients and practice.

Days upon days of laborious inquiry were held to learn every facet of operations.

No physician billed the State for his services and each bore his own travel expenses.

The other costs, such as attorney fees and court reporting, were borne by the Medical Association of Georgia.

The results were good.

They have been far-reaching.

Georgia Transformed

A substantial beginning has been made, and when the course charted in the report is followed to its ultimate, Georgia will be transformed to leadership. The vacuum which previously existed will have been filled, through the efforts made by the medical profession of Georgia and the confidence which they commanded from the people, the General Assembly and the Governor.

As an immediate result of this report the following recommendations of the committee have been carried out: Transfer of the Milledgeville Hospital and Gracewood facilities to the Georgia Health Department; the enactment of new laws on commitment procedures; the authorization for financing and constructing large scale facilities to handle this program; the administrative implementation of many internal reforms at the hospitals; and the appointment of the Governor's Advisory Committee on Mental Health.

In other words, within a period of two years after the committee's report, practically all of its major recommendations were either enacted into law or carried out by administrative action.

Another example of this type of leadership was the work of the medical profession of Georgia in shaping and guiding the enactment this year of the Georgia Medical Assistance for the Aged Act of 1961.

After the 1960 Congress had taken action on the subject of medical assistance for the aged, the Medical Association of Georgia emphasized the necessity for state legislation to implement the Federal act.

The Association prepared and submitted a bill for consideration by the legislature.

Various members met with committees of both Houses and gave their views.

Aged Care Due to MAG

They also talked with the members of the General Assembly from their home counties.

After a compromise Act was adopted, they assisted the Welfare Department in setting up the administrative machinery to carry out the purposes of the law.

The Association then entered into a contract with the Welfare Department to provide medical consultation for the program.

The success of the Medical Care for the Aged program will be largely due to the effective work of the Medical Association of Georgia.

What has been demonstrated in the fields of mental health and medical care for the aged is an example of what can be done in other fields and on the local level through professional interest and action. I refer to hospital administration, availability of nursing care, sanitation recommendations, water pollution control, epidemic control, disease prevention, health studies, health education, recreational activity and a host of other things affecting and conducive to a more healthy environment for our people.

Legal Profession Contributes

Time does not permit discussion here of the many notable contributions of the legal profession in the fields of public service in recent months. But I do want to say that the profession, as such, and the medical profession would do well to become interested in better governmental administration at all levels of public activity. Business does it constantly. The results would be untold benefit in the form of better services for all the people.

It is easy to see, therefore, that physicians and lawyers who have the confidence and respect of the great masses of people whom they serve, can be a potent force for more effective government. For this reason they are not entitled to take public opinion

as a directive; they have rather an affirmative duty to help mold public attitudes.

I do not suggest that our professions as such become embroiled in partisan affray. Far from it. I do suggest that the professions associate themselves with the public interest and that their great reservoir of good will be utilized to further that interest and to promote sound government, efficiently operated for the people's interest, securing a dollar's worth of benefits and services for every tax dollar expended.

If our system of government and society are to survive, its keenest and most disciplined minds—and by and large this means its professional men—must devote their moral energies and their best thoughts toward becoming leaders in solving its problems.

America's survival is our obligation.

*Georgia Court of Appeals
Judicial Building
Atlanta 3, Georgia*

INVESTIGATIONS LAUNCHED FOLLOWING DRUGS' TRAGIC SIDE EFFECTS *

Reports of possible serious side effects of three drugs led to studies and investigations by the drug industry, the American Medical Association and the Federal government.

Most attention was given to thalidomide, a non-barbiturate which produces sleep without a "hang-over." Births of malformed babies, mostly in foreign countries, by mothers who took the drug during pregnancy were widely reported.

The Pharmaceutical Manufacturers Association established a special drug safety group to broaden scientific knowledge regarding predictability of the effect of potent drugs on humans.

The AMA started a special study of thalidomide. A Senate subcommittee opened an investigation. One of the first official acts of the new secretary of Health, Education and Welfare, Anthony J. Celebrezze, was to order a tightening of FDA controls over drug testing.

Thalidomide was first marketed in West Germany about five years ago. It was consumed widely in West Germany, Great Britain, Australia, Portugal and Canada. One of its uses was as an antidote for the morning sickness of early pregnancy. No significant side effects, either proved or suspected, were reported until 1961.

The parent company of Wm. S. Merrell Co. of Cincinnati, Ohio, obtained in 1959 the North American marketing rights for the drug. Merrell conducted laboratory and mass clinical tests, put the drug on the market in Canada and in September 1961, applied for FDA approval for U.S. sales.

Dr. Frances O. Kelsey, a newly employed medical officer at FDA, moved cautiously on the application and withheld approval. In February 1961, she read a letter in the British Medical Journal suggesting that thalidomide might be causing peripheral neuritis.

For withholding FDA approval of the drug, Dr. Kelsey was awarded the Distinguished Federal Civilian Service Medal by President Kennedy. The President at the same time renewed his request to Congress that it approve the Administration's drug legislation.

First reports linking thalidomide with birth malformations reached Merrell from the German drug manufacturer in November 1961, after a German scientist reported such indications at a medical meeting. Merrell promptly sent a warning to Canadian doctors and the approximately 1,200 American doctors conducting clinical tests with it. It was requested that the drug not be given to women of child-bearing age. Merrell so advised the FDA at the time also. In early March 1962, Merrell withdrew the drug from the Canadian market and experimental use in this country, and dropped its FDA application.

The PMA announced establishment and financing of a Commission on Drug Safety to, among other activities, "investigate an unpredictable problem which is assumed to be connected with use of the European drug (thalidomide)." Lowell T. Coggeshall, M.D., a leading U.S. scientist and vice president of the University of Chicago, was named chairman of the commission. He formerly was president of the American Association of Medical Colleges and of the American Cancer Society.

"The basic purpose of our commission is to study the broad and complex problems of making available to the public, with adequate safeguards for both the doctor and the patient, the therapeutic advances which will result from the enormous programs and rapid pace of medical research," Coggeshall said.

"However promising new agents may be in the laboratory, no amount of laboratory experimentation and testing can provide complete assurance of effectiveness or safety when a new drug is administered to a human being. We must attempt to reduce danger to the lowest possible degree without discouraging the imaginative research from which flows mankind's increasing release from disease."

The AMA Council on Drugs began a comprehensive analysis of the effect of thalidomide on unborn infants.

In a statement, the council said:

"The AMA has been concerned about the reports of distinctive congenital malformations occurring in the offspring of patients receiving thalidomide in early pregnancy. . .

"It has been under clinical evaluation here since

*From the Washington office of the American Medical Association, August 8, 1962.

INVESTIGATIONS / Continued

1956. There have been no published reports in scientific journals of such malformations developing in connection with these trials in the United States.

"On the evidence which has been presented, it would appear that the increased incidence of extremelia in Germany, Great Britain and Australia may be related to the use of thalidomide during the early weeks of pregnancy.

"A careful analysis of the whole problem is needed. This has not yet been done and the Council on Drugs proposes to undertake a comprehensive analysis. Through such studies, it is hoped that further knowledge will be gained on the problem of congenital malformations and appropriate measures will be determined to safeguard our population."

FDA Commissioner George P. Larrick and Dr. Kelsey both agreed in testifying before the Senate Subcommittee that Merrell had acted with reasonable diligence in withdrawing thalidomide from the market. Dr. Kelsey said that if the entire matter had been up to her alone she would not have withdrawn it much sooner than the company.

Larrick also said then that the FDA had not found any infants born deformed in this country as a result of thalidomide administered in the mass clinical testing program. But he said the birth of deformed infants in this country had been reported where mothers had taken the drug after it had been procured in other nations where it had been marketed.

A Federal grand jury was investigating Merrell in connection with another of its drugs, MER-29, which was designed to inhibit formation of cholesterol in the blood.

The FDA in April 1960, approved an application for marketing the drug. It was an instant success. But it was withdrawn in April of this year after reports that some patients taking it had developed eye cataracts, and had suffered hair loss, skin changes and leukemia.

The AMA Council on Drugs recently reported that "much longer and more careful studies" were needed to prove the safety of the drug in general or long-term use.

The FDA also investigated enovid, a birth control pill. The FDA said there had been 28 cases reported since September in which women given the contraceptive pill developed a blood clot called thrombophlebitis. Six of them died. But the agency cautioned that fatal blood clots can be caused by many things unrelated to any drug.

The pill's manufacturer, G. D. Searle and Co. of Chicago, said a "super-charged atmosphere over thalidomide" was responsible for the FDA's investigation of enovid.

The company said a woman taking oral contraceptives runs no more risk of blood clots than a woman in normal pregnancy.

It was the second investigation ordered into the contraceptive pill since it was approved for commercial sale in May 1960, on the basis of what the FDA called "extensive research data."

WM. S. MERRELL THALIDOMIDE TELEGRAM

Medical Association of Georgia
938 Peachtree Street, N.E., Atlanta

Persistent press pressure in certain areas demands names of physicians conducting clinical trial with thalidomide. Merrell cannot violate traditional confidential relationships with drug investigators by making their names public. Merrell supplied names to Food and Drug Administration April 1962, and names have been released from Washington to state and local public health officials. First word of a possible effect of thalidomide on the unborn child reached us by cable from Germany late November 29, nearly three years after trials began in this country. Within hours we notified the Food and Drug Administration and shortly afterwards doctors active in the program. We have offered our scientific resources and cooperation to the FDA, the American Medical Association and to other scientists working on this problem. July 30, the AMA Council on Drugs announced it will undertake a comprehensive analysis of the problem. Merrell is co-operating 100 per cent with the Council. We do not minimize possibility that thalidomide may be connected with congenital malformations in some way not now understood. Major part our research effort is devoted to ascertaining what relationship there may be or whether there is indeed such a relationship at all.

Last March we terminated the clinical program and asked participating doctors to return their drug supplies. Merrell has carried out an extraordinary program to assure that these clinicians return or destroy all test quantities of the drug in their hands. Virtually all Merrell executives and 30 other picked personnel at our headquarters in Cincinnati collaborated in massive effort to reach all physicians by telephone and letter. Merrell field representatives have called on many of the doctors at their offices. We have followed up personal contacts with telegrams and registered letters to get as full an accounting of the disposition of the drug as possible. Merrell representatives have tried to find ways of checking the drug stocks of deceased physicians. The heart-breaking tragedy of the malformed babies in Europe reportedly related to the drug thalidomide has caused deep concern to Merrell people as well as to all other Americans. We know many have feared that a similar tragedy could occur as a result of our clinical testing program with thalidomide. We now have reason to believe that if there ever was in fact such a danger it is now a slight one. These facts supplied for your information with hope you may allay understandable anxiety in your state by announcement to member physicians.

John B. Chewning, M.D., the Wm. S. Merrell Co., Cincinnati 15, Ohio.

SOME CURABLE TYPES OF METABOLIC BONE DISEASE

Thomas Findley, M.D., Augusta

THE LITTLE MEN in Figure 1 who are busily building and destroying bone represent, respectively, osteoblasts and osteoclasts. The function of the osteoblast is to lay down matrix; the rate at which this is done is measured by the concentration of alkaline phosphatase in serum, and the most important stimulus

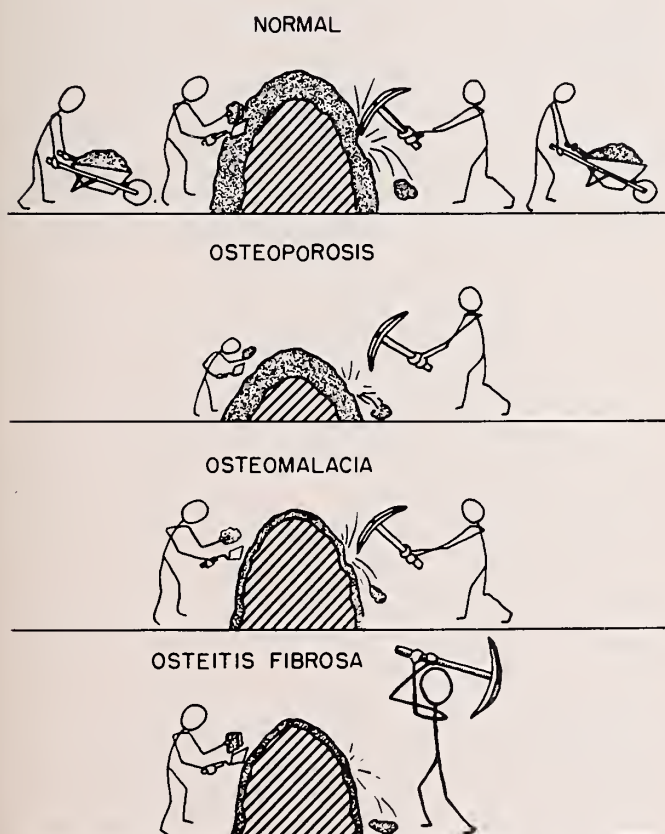


Figure 1 — Metabolic Bone Disease

In *osteoporosis* the bone is normal, but there is too little of it. In *osteomalacia* the matrix is normal but calcification is incomplete because the supply of calcium and phosphate ions is inadequate. *Osteitis fibrosa* occurs when parathormones have converted osteoblasts into osteoclasts.

to new bone formation is physical activity. Failure to lay down matrix as rapidly as bone is destroyed causes *osteoporosis*. The microscopic picture is that of normal bone—but not enough of it.

* We are indebted to the American Clinical and Climatological Association for permission to reproduce Figs. 5, 6, 7, 8 and 9. From the Department of Medicine, Medical College of Georgia, Augusta, Georgia. Read at the 108th Annual Session of the Medical Association of Georgia, Savannah, Georgia, May 8, 1962.

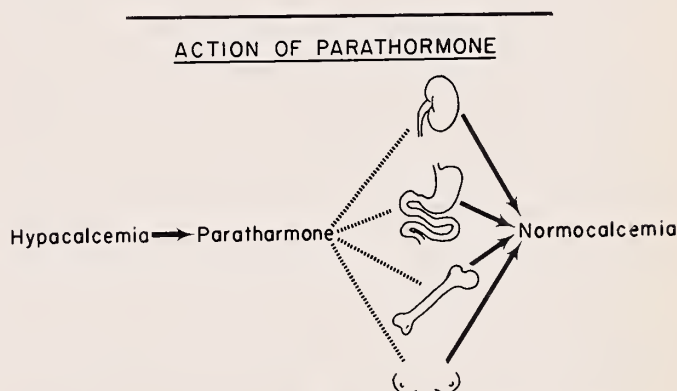


Figure 2

In response to a hypocalcemic stimulus, the parathyroid glands secrete a hormone which facilitates the resorption of calcium from urine, feces, milk, and bone. Attainment of the normocalcemic state then inhibits parathormone secretion, except in cases with tumor or autonomous hyperplasia.

Matrix must then be calcified by the deposition in it of a complex mixture of mineral salts called *hydroxyapatite*. The most important factors here seem to be the concentrations of calcium and phosphate ions in serum and the action of vitamin D. Failure to calcify matrix properly causes *rickets* in children and *osteomalacia* in adults. This may be due to an inadequate supply of calcium, phosphate, or both. The citrate ion is also probably somewhat important.

Ordinarily, the rates of bone formation and bone destruction are equal but the parathyroid hormone (parathormone) is apparently able to stimulate bone destruction by converting osteoblasts to osteoclasts.¹ The effect of this is *osteitis fibrosa*. Here also the alkaline phosphatase content of serum is high, although the rate of new bone formation is never able to replace that which is destroyed. The stimulus to parathormone secretion is *hypocalcemia* (Fig. 2). When this occurs for any reason, the hormone salvages calcium from all available sources (bone, urine, feces, and milk are the important reservoirs). Under physiological conditions the hypocalcemia is therefore quickly corrected, but uncontrolled autonomous activity of the parathyroid glands due to tumor or hyperplasia will obviously result in sus-

tained hypercalcemia, hypercalciuria, probable kidney stones, and destruction of the skeleton. So far as is known, the parathyroid glands are not controlled by other endocrine glands.

These are the three important metabolic bone diseases which can be effectively treated. Increased matrix formation may be seen in recently healed osteomalacia, and decreased bone destruction occurs in hypoparathyroidism and in osteopetrosis (Alber's Schönberg disease) but these are not numerically important disorders.²

Osteoporosis

Figure 3 shows the spine of a 62-year-old woman with osteoporosis (ETMH # 018-334), presumably of post-menopausal origin. Note that the aorta casts a heavier shadow than the spine does and that the intervertebral discs are harder than the vertebrae. Most radiologists would not rule out osteomalacia or osteitis fibrosa from this study alone, but the diagnosis is established by a normal skull X-ray and by a normal serum alkaline phosphatase concentration.

This is probably the least "curable" of the diseases herein discussed. Efforts to stimulate osteo-

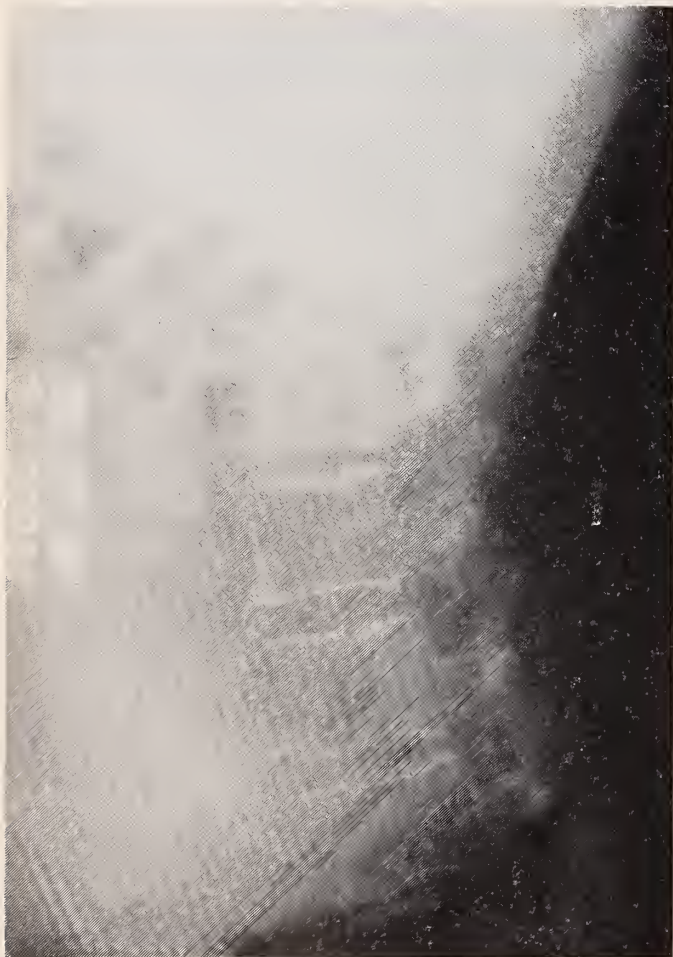


Figure 3 — Osteoporosis

The cartilaginous discs are harder than the vertebrae and the aorta looks as dense as the spine. The skull and serum alkaline phosphatase content of this post-menopausal woman were normal.



Figure 4 — Osteomalacia

The entire skeleton, including the skull, was as demineralized as these bones of the feet. There may have been an element of hyperparathyroidism here too, since she was slightly hypophosphatemic and hyperphosphaturic, but the pain responded quickly to vitamin D and serum alkaline phosphatase dropped to normal.

blastic activity are made by prescribing as much physical exercise as seems feasible and by administering anabolic hormones. Stilbestrol has been widely used for years in a daily dosage of about 1 mg., but vaginal bleeding may occur. Methyl testosterone sublingually in a daily dosage of 10 mg. has also been used for its ability to promote nitrogen retention, but this amount may masculinize females. It is better to use predominantly anabolic steroids such as Dianabol (CIBA), Adroyd (PARKE-DAVIS), or Durabolin (ORGANON) since their masculinizing effects are minimal. It is probably unnecessary to add calcium gluconate or vitamin D unless the patient's dietary history clearly suggests an inadequate intake. If the loss of bone matrix (protein) has been due to Cushing's disease, cortisone administration, diabetes mellitus, thyrotoxicosis, eunuchism, starvation, or prolonged immobilization, appropriate measures will suggest themselves. "Idiopathic" cases are peculiarly resistant to treatment. In any event, pain relief and increased vigor comes slowly and one must not expect striking radiological evidence of increased bone density.

Osteomalacia (Adult Rickets)

Here the matrix is normal but calcification is defective because of a deficiency of calcium ions, phosphate ions, or both. Rickets due to an inadequate intake of calcium or vitamin D is practically unheard of in the western world now, but there are numerous other pathways to the same end result—a relative increase in the amount of uncalcified osteoid and osteoblastic activity. The radiologist sees “soft bones”—as the word *osteomalacia* implies—and, if the process is acute, linear pseudo-fractures also appear (Looser's lines, Milkman's disease). In contrast to osteoporosis the skull may become quite radiolucent and the serum alkaline phosphatase high. Bone pain may be excruciating.

Figure 4 shows the foot of a 70-year-old white woman (ETMH # 018-448) whose bone pain was so severe that she had had a laminectomy for supposed ruptured intervertebral disc. The cause of her osteomalacia was never quite understood, but it responded promptly to large doses of vitamin D.

A. The commonest causes of osteomalacia due to *calcium deficiency* are, (1) the malabsorption syndrome and (2) increased resistance to vitamin D. The co-existence of sprue, pancreatic insufficiency, Whipple's disease, etc., is usually apparent, but the



Figure 5 — Renal Osteodystrophy

The masses over both shoulders of this uremic woman are calcium deposits. The nodules on the face and sternal area are sebaceous cysts.

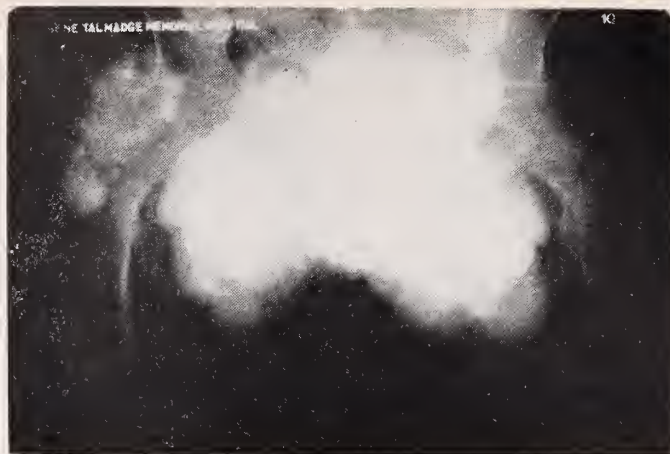


Figure 6 — Renal Osteodystrophy
Metastatic calcification before parathyroidectomy.

nature of this defect in the metabolism of vitamin D is not at all so. It is characteristically seen in disorders of renal tubular function which manifest themselves by aminoaciduria, glucosuria, hypercalciuria, or hyperphosphaturia in various combinations. The tubular transport mechanisms for these substances are obviously defective, often for genetic reasons, and the most exaggerated example is the full-blown Fanconi syndrome. Renal tubular acidosis probably also falls into this category. The sequence of events leading to bone disease may be, *increased vitamin D resistance* → *hypocalcemia* → *osteomalacia*.

B. Osteomalacia due to *phosphate deficiency* has occurred after prolonged ingestion of aluminum hydroxide gel but not as a result of dietary restriction alone.

Osteitis Fibrosa

Recent advances in the purification of parathormone³ show that it is a single protein which acts directly on bone by stimulating osteoclasts in response to the stimulus of hypocalcemia. In bone, however, calcium is bound largely to the phosphate ion and this is ordinarily disposed of in the urine, a process which the hormone also facilitates by stimulating phosphate secretion by the distal convolution. The diagnosis of *primary hyperparathyroidism* in patients with adequate renal function is ordinarily not difficult, since it is characterized by hypercalcemia and hypercalciuria, by hyperphosphaturia with a serum phosphate concentration at or below the lower limits of normal, by an increase in serum alkaline phosphatase, by nephrocalcinosis in about 80 per cent and by a radiolucent skeleton with or without cyst formation in about 20 per cent of the cases.³ A very good place to look for sub-periosteal bone resorption is in the terminal phalanges of the hand (Fig. 7).

Secondary hyperparathyroidism is a very different matter. Since hypocalcemia not only impedes calcification of the matrix but also activates the para-

METABOLIC BONE DISEASE / Findley

thyroids, rickets and hyperparathyroidism often co-exist, *increased vitamin D resistance* →

hypocalcemia → *osteomalacia*
osteitis fibrosa

If adequate doses of vitamin D are given before parathyroid activity becomes autonomous, both of these bone diseases will heal.

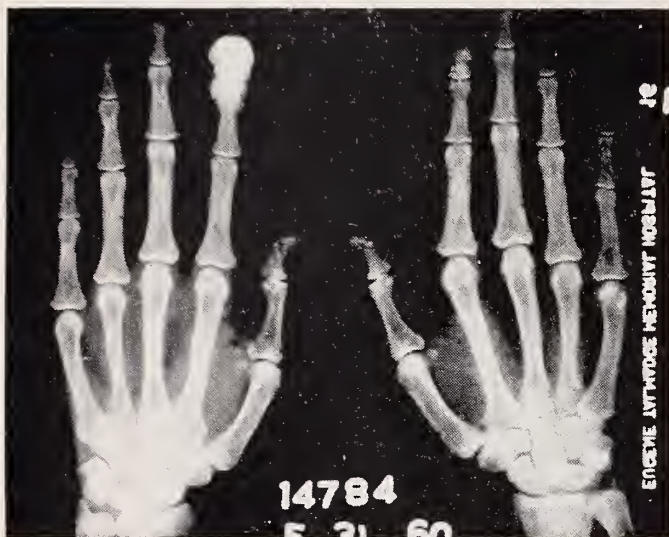


Figure 7 — Renal Osteodystrophy

Three metabolic diseases are evident here pre-operatively. (1) Subperiosteal bone resorption of the terminal phalanges, particularly, and the metastatic calcification in the left index finger indicate hyperparathyroidism. (2) Diffuse radiolucency suggests osteomalacia, and (3) the carpal bones are spottily osteosclerotic.

Renal Osteodystrophy

This is a descriptive term applied to patients with various combinations of renal and skeletal disease. From the renal standpoint, it is convenient to divide patients into those with and those without azotemia. Mixtures of osteomalacia and osteitis fibrosa are the commonest bone disorders, but uremic patients may, for unknown reasons, also show areas of increased bone density (osteosclerosis) (Fig. 7).

(A) *Tubular osteodystrophy* has been alluded to in the section on osteomalacia. These patients have adequate over-all renal function and no proteinuria. The nature of the decreased response to vitamin D is not understood.⁴ Neither is it known whether the phosphaturia is due solely to secondary hyperparathyroidism as originally postulated by Albright, or to an intrinsic renal defect;^{5,6} but adequate doses of the sterol (200,000-400,000 units daily) usually produce healing of both types of bone disease and also often diminish the aminoaciduria, the calciuria, the phosphaturia and the other evidences of disordered tubular function, including even the metabolic acidosis.^{4,6,7} Until proved otherwise, we will regard the phosphaturia and hypophosphatemia of vitamin D resistant rickets as manifestations of secondary hyperparathyroidism.

(B) *Uremic osteodystrophy* is also a mixture of adult rickets and secondary hyperparathyroidism, but the reason why azotemia interferes with the action of vitamin D upon the gut and the bones is unknown.⁷ There is evidently something in uremic serum which disturbs the metabolism of the vitamin. In any event, glomerular failure leads to phosphate retention and this in turn to a reciprocal drop in serum calcium content. The parathyroids therefore enlarge, sometimes hugely so, and osteitis fibrosa may become the predominant skeletal lesion. Renal function may be so poor that the phosphate ion liberated from bone as parathormone in excessive amounts destroys the skeletal cannot properly be excreted in the urine; the *calcium x phosphate* ion product therefore rises to such heights that precipitation in soft tissue occurs. The important bone lesion in uremic osteodystrophy is osteomalacia, however, but treatment with vitamin D is hazardous in the presence of severe hyperparathyroidism because the borderline between the dose necessary to heal osteomalacia and that which induces hypercalcemia is slim. Stanbury^{8,9} astutely suggested that such patients should be subtotally parathyroidectomized first. The actions of vitamin D and parathormone overlap in large areas because both substances enhance the absorption of



Figure 8 — Renal Osteodystrophy

A year after sub-total parathyroidectomy the ectopic calcification has disappeared, although she is still uremic and osteomalacic.

calcium from the bowel; but the hormone produces phosphaturia, while the first evidence of vitamin D activity is usually a rise in serum phosphate concentration due to diminished tubular secretion.

We have fully confirmed Stanbury's views in one patient (ETMH 022-010) with long-standing chronic glomerulonephritis and secondary hyperparathyroidism.^{10,11} Figures 5, 6 and 7* show the extensive metastatic calcification pre-operatively when her BUN was about 170 mg. per cent, serum calcium 7.7 mg. per cent, serum phosphate 10.7 mg. per cent, and serum alkaline phosphatase 55 KA units. Fig. 7 shows the marked sub-periosteal bone resorption as well as areas of osteosclerosis and metastatic calcification in the hand. Three greatly enlarged parathyroids were removed with striking results; the fourth could not be found but mild post-operative tetany occurred which was easily controlled with calcium gluconate by mouth for a few days. Figures 8 and 9 show the remarkable speed with which the abnormal calcium deposits disappeared (presumably the calcium went into bone though no metabolic studies were done). The osteitis fibrosa healed promptly and it then became possible to treat the residual osteomalacia safely with large doses of vitamin D. Bone pain was promptly relieved and the increased sense of well-being was striking. The patient lived in relative comfort for nearly a year after this procedure. The azotemia and hypophosphatemia did not increase appreciably until just before her sudden death.

Summary

The kidney plays an important role in the pathogenesis of osteomalacia and osteitis fibrosa, two metabolic diseases which are curable by large doses of vitamin D. The nature of the increased resistance to the action of this sterol is discussed in terms of glomerulae and tubular dysfunctions. Sub-total parathyroidectomy has a place in the treatment of uremic osteodystrophy. Osteoporosis is a less tractable disorder.

Medical College of Georgia

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Figure 9 — Renal Osteodystrophy

Almost all the ectopic calcification has disappeared a year after operation. Osteomalacia is healing under the influence of vitamin D. Both femoral necks are broken but she is pain-free when off her feet.

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MIAMI SITE FOR SOUTHERN MEDICAL ASSOCIATION MEETING

The Southern Medical Association will hold its Annual Meeting November 12-15, 1962, at the Fontainebleau Hotel, Miami Beach, Florida. Exhibits of high caliber are solicited for the Scientific Section. Applica-

tions may be obtained from the chairman of the Scientific Exhibit Committee, George F. Schmitt, M.D., 30 S. E. 8th Street, Miami, Florida.

ENDOMETRIOSIS OCCURRING IN A POSTOPERATIVE RADICAL VULVECTOMY SCAR

D. R. Sondag, M.D.; John D. Thompson, M.D.; and Herbert W. Birch, M.D., *Atlanta*

■ ***Stenosis of the vaginal introitus resulted
from this unusual complication.***

IN 1958, (DRS.) RIDLEY AND EDWARDS¹ obtained evidence to support the validity of Sampson's implantation theory of endometriosis by the injection of menstrual blood into the anterior abdominal wall of volunteer patients who were to undergo pelvic laparotomy. (Drs.) Ridley and Sommers² have continued this work. They have shown two successful growths of endometrial tissue in these sites. During the years prior to this experiment, there have been several case reports^{3,4,5,6,7} of endometriosis in vaginal and vulvar operative sites which strongly suggested the probability of implantation of endometrium desquamated at menstruation. They were never accepted as proof of this theory because the lesions were not extragenital. In addition, some of the cases had an associated uterine operation (usually a D & C) which could have accounted for an accidental direct implantation of viable endometrial tissue. However, in Rothman's "Review of Endometriosis of the Vulva,"⁸ four of the eleven cases occurred in operative sites (incision of a Bartholin abscess) without mention of a D & C being performed. Two other cases of endometriosis at this site have been reported by (Dr.) Healy⁹ and (Drs.) Duson and Zelenik.¹⁰ In these reports, it was stressed that no D & C was done.

The following is a case of endometriosis occurring in the operative site of a radical vulvectomy for squamous cell carcinoma of the vulva.

Case Report

History: J. J. is a 39-year-old Negro female who was admitted to Grady Memorial Hospital on November 3, 1960, for surgical correction of a marked stenosis of the vaginal introitus.

She dates the onset of the original illness to 1949, at which time she noted a painful swelling of the left labia majora, soon followed by a lesion on the opposite labia. There was marked hypertrophy of both labia minora with patches of hypertrophic tissue on the left labia majora and bilateral inguinal swelling. She was treated elsewhere for granuloma inguinale with streptomycin and tetracycline. In January 1956, she was first referred to Grady Memorial Hospital where pelvic examination demonstrated a 3 x 4 x 6 cm, red ulcerated mass on the left labia majora extending to the left buttock. A similar but smaller lesion was present on the right labia majora. In the left inguinal area there were nodes measuring 3 cm. Biopsy of the labial lesion revealed squamous cell carcinoma. The Frei test and smears for Donovan bodies were negative.

On February 23, 1956, a radical vulvectomy was done. The skin sutures were removed March 7, with subsequent dehiscence of the operative site in the perineal area. She had a normal menstrual flow on March 12-17. The patient received daily perineal lavages and the wound healed secondarily by granulation. On March 26, a bilateral groin dissection was done. The pathology report revealed squamous cell carcinoma of the vulva without metastases to the inguinal nodes. She was discharged May 16, 1956.

Presented at 107th Annual Session of the Medical Association of Georgia, May 9, 1961, Atlanta, Georgia.

Examination on May 29, 1956, demonstrated the vaginal introitus to be stenosed to a diameter of 0.5 cm. In spite of marital complications and divorce in 1957, the patient refused corrective surgery until November 1960.

Physical Examination

The general physical examination was unremarkable except for the pelvic examination. The vaginal introitus was stenosed to a diameter of 0.5 cm. Posteriorly, in the region of the fourchet, there was a thick, hard, fibrous band across the introitus. This band was 2.5 cm. thick in some places. It extended from the anus to the introitus and laterally toward the ischial tuberosities. The external urethral meatus was visible immediately behind the stenosed introitus. The vagina was sounded to a depth of three and one-half inches and a vaginogram confirmed the normal capacity of the vagina above the introitus. The uterus and adnexa were normal to palpation.

On November 7, an operation to enlarge the introitus was performed. A vertical incision similar to a midline episiotomy was made from the vaginal opening to 1 cm. above the anus. The underlying thick core of tissue was excised. The margins of the skin and vaginal mucosa were mobilized and then re-approximated transversely, increasing the diameter of the introitus. A balsa wood mold, 3.5 cm. in diameter, covered by a conform, was inserted.

The patient was given Stilbestrol 5 mgm q.d. for the next 28 days to delay menstruation. The operative incision healed primarily except for a small area of separation in which healing was complete by December 6. She learned to remove and reinsert the vaginal mold and was discharged on November 23. There had been no contracture of the vagina in the following six months. The introitus admits three fingers and coitus is satisfactory.

Pathological examination of the tissue removed at operation revealed extensive fibrous tissue proliferation and endometriosis. Because of this, the patient was questioned about the occurrence of symptoms which might have been related to her menstrual cycle. She denied having had any sensation of pain or swelling around the introitus at the time of menstruation.

A review of the vulvectomy slides showed no evidence of endometriosis in the original vulvectomy specimen.

Comment

Three factors may have contributed to the development of the stenosis of the vaginal introitus:

1) The vulvectomy was done on tissue previously affected by a granulomatous venereal disease—the original lesion on the vulva was said to be granuloma

inguinale, although this was never confirmed. It is likely, however, that some form of granulomatous venereal disease involving the vulva was present initially. Fibrous tissue proliferation in tissues so affected is always present to a greater or lesser degree.

2) There was breakdown and healing by secondary intention of the original radical vulvectomy incision—when an incision heals by granulation secondarily, there is always a greater amount of fibrous tissue formed.

3) Endometriosis developed in the site of the original vulvectomy—as pointed out in the case report; the patient had a normal menstrual flow shortly after the vulvectomy incision broke down. The timing was perfect for bits of shed endometrium to become implanted in this area of fresh granulation tissue. The pathologist's finding of extensive endometriosis in this tissue leads us to the conclusion that the stenosis of the vaginal introitus was due to endometriosis. In our opinion, neither of the other above mentioned factors, alone or in combination, could have caused such a stenosis, although each may have contributed to it.

Although this is the only case in the literature reviewed of endometriosis occurring in a post-operative vulvectomy scar, we feel the pathogenesis (i.e. implantation) is the same as endometriosis in other operative sites. There is no evidence to suggest that the endometriosis of vulva in this patient is an extension from endometriosis elsewhere in the pelvis. Although she has not had a pelvic laparotomy, there is no clinical evidence of pelvic endometriosis.

In the experiments mentioned above by Ridley and co-workers, it is noted that endometrial growths were obtained in only two of 15 patients. This suggests that there is either an individual patient susceptibility to endometriosis, or that most of the endometrium shed at menstruation is not viable or at least incapable of growth. This, coupled with the infrequency of breakdown of vulva and vaginal operative

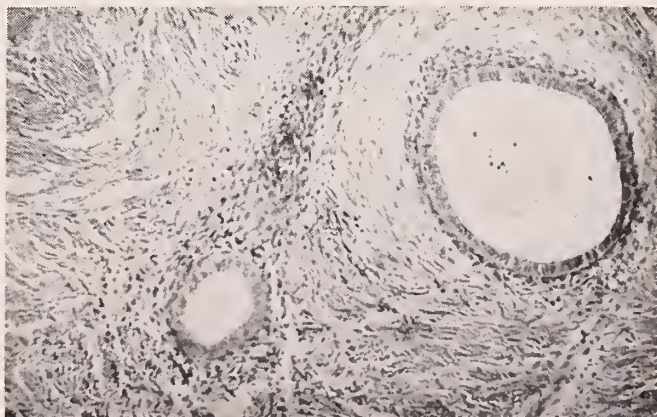


Figure 1

Sections through excised scar tissue from around the stenotic vaginal introitus demonstrating endometrial glands and stroma.

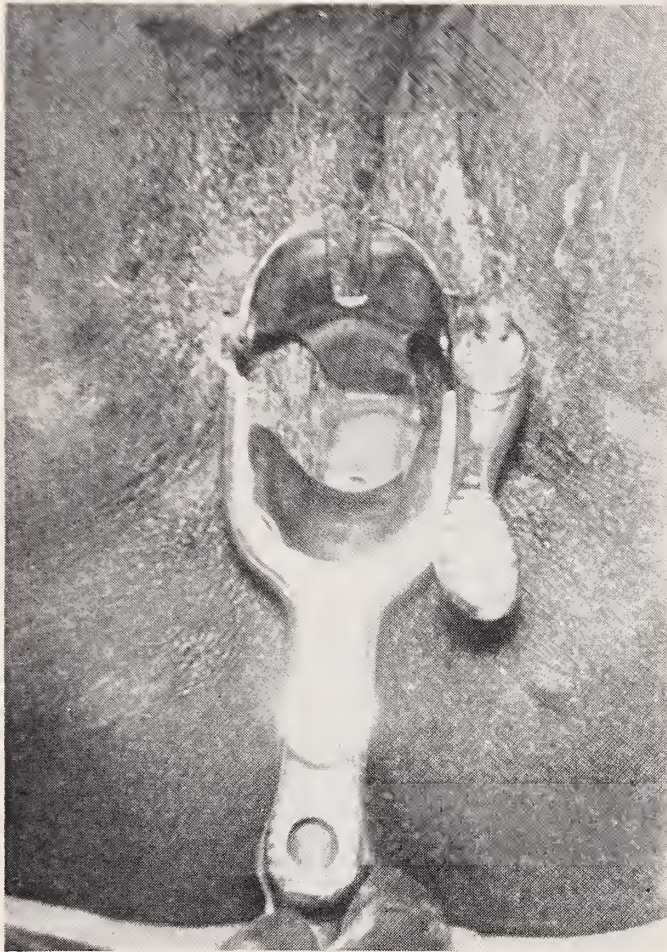


Figure 2

Speculum inserted into vagina six months after revision of the vaginal introitus to demonstrate its adequacy.

sites at the time of menstruation, may account for the rarity of this complication.

Because this patient developed endometriosis in the original vulvectomy site, we elected to delay menstruation in the post-operative period following revision of the vaginal orifice. This was done by administering Stilbestrol by mouth. The possibility that menstrual endometrium may implant in granulating vulva and vaginal incisions should be considered more often. If such operative sites do not heal promptly, an attempt should be made to delay menstruation by giving estrogens.

Summary

1. A case of endometriosis occurring in a vulvectomy operative site and resulting in stenosis of the vaginal introitus is presented.
2. The pathogenesis and possible prevention of this complication is discussed.

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CLINICAL CENTER STUDY ON REITER'S SYNDROME

The cooperation of physicians is earnestly solicited in the referral of patients for a study of Reiter's syndrome conducted by the National Institute of Arthritis and Metabolic Diseases in the Clinical Center of the National Institutes of Health, Bethesda, Maryland. Renewed efforts are being made to recover and identify the causative agent of Reiter's syndrome.

Reiter's syndrome is characterized by a triad of arthritis, urethritis and conjunctivitis. Cases lacking conjunctivitis would still qualify for this study. The presence of gonococcus and urethral discharge would not preclude a case from this study, provided this organism is not present in the synovial fluid. The appearance of cutaneous manifestations (balanitis, keratoderma blen-

norrhagica, maculopapular eruption on penis, hard papules on soles) help clinch the diagnosis. Reiter's syndrome lasts for an average of six weeks and recurs in about 50 per cent of the cases. Most desirable are cases within the first two weeks of onset.

Accepted patients will be studied for several weeks. Upon completion of their study, patients will be returned to the care of their referring physician who will receive a complete narrative summary.

Physicians who wish to have patients considered for this study may write or telephone:

Joseph J. Bunim, M.D.
Clinical Director, National Institute
of Arthritis and Metabolic Diseases
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PRIMARY HEMORRHAGIC THROMBOCYTHEMIA TREATED WITH MYELERAN

Bruno Eisen, Major, MC* and
William C. Butz, Colonel, MC**

THE ENTITY PRIMARY hemorrhagic thrombocythemia has received recent attention in the literature and has been the subject of an excellent review.¹ In the antecedent literature many synonyms have been proposed although as the true mechanism of the entity has emerged, a more suitable nomenclature has appeared.² The association with polycythemia vera has been a continuing fundamental relationship and has apparently aided in proper classification and explanation of the cause of this disease. The purpose of this paper is to report an experience with a case treated with Myeleran and to compare the efficacy of the treatment with the more standard therapy with P-32.

Case Report

The patient was a 57-year-old white female who was admitted on 4 February 1961, to the Surgical Service because of hematoma of the left anterior leg. She had fallen on the ice the preceding day and over a period of 24 hours, symptoms of local heat, pain and edema in the right lower leg developed (Fig. 1). The patient revealed a history of easy bruising all of her life. She had excessive menses requiring hysterectomy at age 46. Prior to this time she had been on protracted treatment with Vitamin K and iron. On several occasions large ecchymoses appeared spontaneously on the head and arms, accompanied by severe nosebleeds and hemorrhagic conjunctivitis. On one occasion hematemesis occurred after prolonged retching.

The paternal family history indicated that the father had frequently exhibited numerous bruised areas. He expired at the age of 77 years from symptoms unrelated to hemorrhagic phenomenon. One daughter, aged 32 years, revealed easy bruising. The pa-



Figure 1

Left leg showing hematoma characterized by discoloration of the skin and some edema. Considerable improvement is manifest compared with the original appearance.

tient's son had been jaundiced during the first six months of life.

Physical examination: On physical examination the patient was a well nourished, well-developed, white female with a pulse rate of 80; respirations of 20 per minute, and a blood pressure of 130/80 mm. of Hg. Examination of the heart and lungs were unremarkable. The liver was 4 cm. below the right costal margin and was firm. The spleen was likewise palpable 4 cm. below the left costal margin. There was a large hematoma involving the anterior aspect of the lower left leg. This was a large area of blue-

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red discoloration involving the anterior surface measuring approximately 6 x 7 cm. Surrounding this area there was considerable erythema. Marked pedal and ankle edema existed.

Laboratory data: A red cell count was 6.4 million cells mm³ with a hematocrit of 55 per cent and hemoglobin 15.5 grams. The bleeding and coagulation times were normal. This study was repeated at Emory University, Atlanta, Georgia, where a hematocrit of 56 per cent was found, with a platelet count of 1,770,000 mm³, clot retraction time ten per cent, with a normal between six and 20 per cent. The tourniquet test was negative. Fibrin index showed a firm clot in four minutes. Lee-White coagulation time was nine minutes with the normal time of 12-21 minutes and the bleeding time was four minutes. The prothrombin time was 17.5 seconds with a control of 15.6 seconds. The serum prothrombin time was 37.5 seconds. The white cell count was 28,420 mm³ with a hematocrit of 57 per cent and platelet count of 710,000 mm³. On 15 March 1961, a third count revealed a WBC of 13,000 mm³ with platelet count of 500,000 mm³. Total protein with AG ratio, alkaline phosphatase, total bilirubin, serum transaminase and BSP were normal. The red cell volume normal was 28 cc. per kilo. with the patient's 23 cc. per kilo.

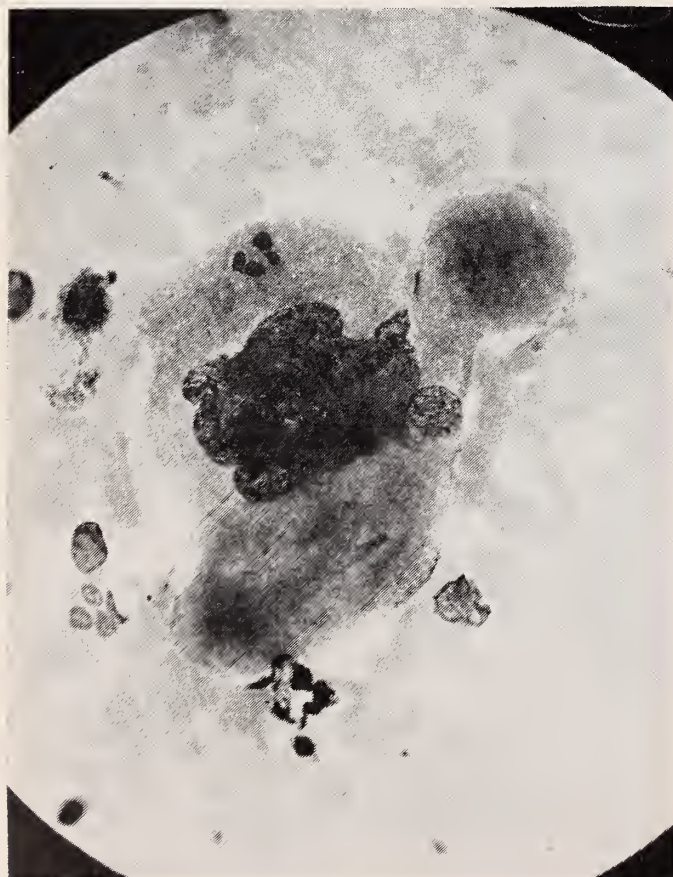


Figure 2

Bone marrow revealing a relative increase in the number of megakaryocytes.

Alkaline phosphatase stain of the leukocytes was 74+; this figure is regarded as high.

The bone marrow showed considerable dilution, but the most striking feature was the large masses of platelets. There was an absolute increase in the number of megakaryocytes, although the elements were not relatively increased.

BONE MARROW

Progranulocytes	1.8%
Myelocytes	4.5%
Metamyelocytes and band forms	23.0%
Neutrophils	29.0%
Eosinophils	1.2%
Basophiles	0.5%
Myeloid series	60.0%
Proerythroblasts	2.0%
Basophilic erythroblasts	6.0%
Polychromatophilic erythroblasts	5.0%
Erythroid series	25.0%
Lymphocytes	11.0%
Monocytes	3.0%
Reticuloendothelial cells	1.0%

The myeloid-erythroid ratio was 2.4 to 1. The bone marrow smears, as a composite, appeared hypercellular. There was little or no fat seen in the cell block. The picture, essentially, revealed a generalized increase in all bone marrow elements, including megakaryocytes. The platelets occurred in masses interspersed among which a number of megakaryocytes were identified (Fig. 2). The bone marrow, despite the considerable dilution was regarded as typical of primary hemorrhagic thrombocythemia. The existence of large numbers of platelets in the presence of an absolute increase in the number of megakaryocytes raises a conclusive presumption that there exists a relative increase in the megakaryocytes (Fig. 3). A bone marrow repeat after the patient had been on Myeleran was regarded as compatible with polycythemia vera, there being a marked myeloproliferative change in evidence.

X-rays of the chest were normal. There was marked soft tissue swelling on leg X-ray but no evidence of bone involvement. Flat plates of the abdomen revealed a moderate splenomegaly. There was an irregularity in the esophagus demonstrated, but this was not diagnostic.

Course in Hospital

The patient was treated with Myeleran, two milligrams three times daily for 21 days, in an effort to reduce the platelet count. After treatment there was a reduction in the white cell count and platelet count. At the termination of treatment, bone marrow revealed no red cell abnormalities, except for a mild poikilocytosis and occasional microcyte. There remained an obvious increase in the number of platelets and white blood cells in the peripheral blood. Frequently, the platelets appeared abnormally large. All white blood cells showed normal morphology with a 2.5 per cent bands and 50 per cent neutro-

philes. Following Myeleran, the bone marrow revealed a generalized hyperplasia which with an elevated peripheral white cell count, red cell count, and platelet count are consistent with a polycythemia vera. In addition, there was a four per cent eosinophilia and a two per cent basophilia in the peripheral blood. In addition to the general treatment outlined above, the patient was given bed rest and ice pack and then continuous saline soaks for the localized hematoma of the anterior aspect of the left leg. The patient's subsequent course has been one of constant improvement. There has continued to be some deficit in circulation within the legs, although this has markedly improved. Five months following treatment, the platelet count ranged between 280,000 and 320,000 mm.³ The effect of the therapy has been regarded as moderately good and while such treatment is not permanent, continuous treatment will probably serve to have a beneficial effect.

Discussion

The bleeding tendency which the patient usually exhibits is not well explained. There is an absolute increase in the number of platelets and the rise and fall in the platelet count is positively correlated with the bleeding tendency. It has been suggested that the fundamental defect in hemorrhagic thrombocythemia is a coagulation defect, resulting from the anticoagulant effects of excessive platelets. With excessive numbers of platelets there is an impairment of the coagulation process by interference with thromboplastin formation and inhibition of the action of thromboplastin.³ This phenomenon could be explained on the basis of repeated thrombosis with subsequent degeneration of the clots, release of excessive amounts of thromboplastin and a total consumption of the fibrinogen. Thus, a vicious circle is set up which will rise to the point wherein there is no longer sufficient fibrinogen to yield satisfactory clotting. Indeed, the fibrinogen levels have been low in one case (160 mg. per cent).⁴ In some cases there has been an increased thromboplastin generation by platelets and increased clotting tendencies and fragmentation of the platelets with decreased proaccelerin activity. In the literature it appears that there is a considerable variation in the coagulation defects in that some patients do not exhibit any change in their coagulation studies. The disease entity has been termed "primary hemorrhagic thrombocythemia" and has been classified along with certain myeloproliferative disorders, especially polycythemia vera and myelometaplasia of the spleen.⁵ The highly individualistic clinical character and hematologic findings are, however, separate from the other many faceted myeloproliferative diseases. The relation to leukemias is uncertain, although here again myeloproliferative changes are re-

garded, at least, as an antecedent general component of the disease entity. Whether idiopathic thrombocythemia occurs as a separate entity from polycythemia, polycythemia vera, or leukemia is debatable.⁶ However, after all secondary cases are removed, a group remains which cannot be classified otherwise. The existence in this case of a basophilia and an eosinophilia is regarded as important and whether there will be a later transition into a leukemia is uncertain. Where there is a relative increase in red blood cells and a fairly high hematocrit, as in this case, it is regarded as closely approximating polycythemia vera. As a diagnostic criterion, a platelet count in excess of one million as an absolute value is regarded as an important criteria in the diagnosis of this disease when taken along with the existence of a hemorrhagic phenomena and other thrombohemorrhagic signs. The efficacy of Myeleran in treating this condition is pointed out. Its action is that of a cytotoxic agent producing a marked reduction in platelets and white blood cells.

Summary

1. A case of primary hemorrhagic thrombocythemia treated with Myeleran is reported. The patient exhibited a marked thrombohemorrhagic phenomenon with some indication that there may be familial relationship, there having been easy bruising in both the father and daughter.

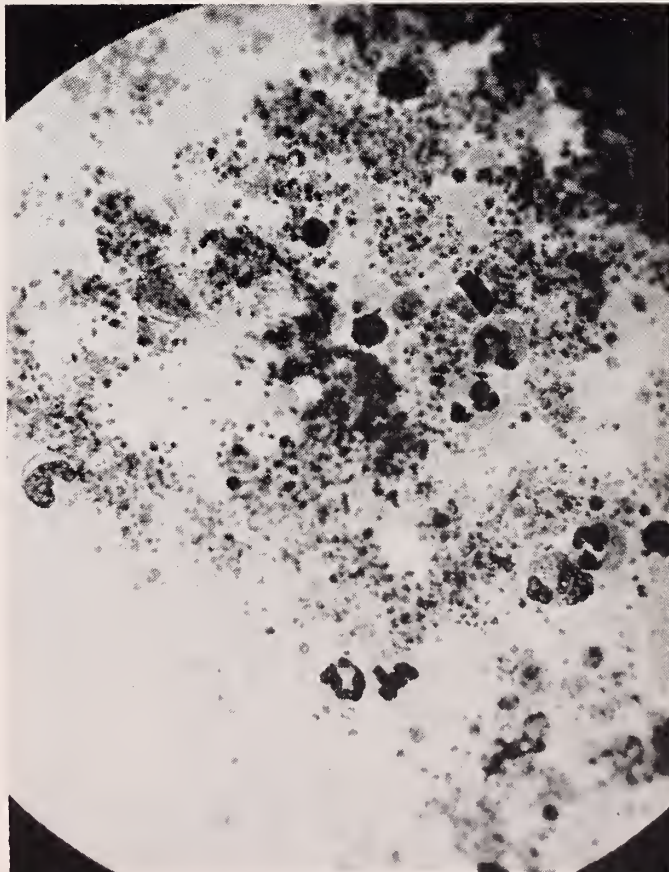


Figure 3

Massive aggregation of platelets within the bone marrow along with excessively high count in the peripheral blood was a salient hematologic findings which accompanied the clinical picture.

2. The basis of diagnosis was a peripheral platelet count in excess of one million, a bone marrow in which there were masses of platelets, and an absolute increase in the number of megakaryocytes. The platelets in the peripheral blood were abnormally large and improperly shaped. The clinical features of repeated episodes of thrombohemorrhagic phenomena combined with the blood picture and bone marrow are taken as diagnostic of this entity.

3. Myeleran is suggested as a safe and an effective means of therapy in patients with primary hemorrhagic thrombocytopenia.

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OF SAILS AND ANCHORS

In President Kennedy's view, the choice before the voters in November is quite clear: Democratic action or Republican opposition to action. The people, he told his press conference, "will choose either to anchor down or to sail."

We agree that the nation does face a serious choice in its domestic policies, though we would express it a little differently. It is a choice between more Government or more freedom from Government for individuals and businesses. And we are far from sure that the Republicans, as the opposition party, will prove capable of presenting it in clear political terms.

Not that the Democrats will have an easy time. The President reasons that if they could pick up only a few seats in Congress they could swing enough votes to efface this year's defeats on such notable matters as farm and medicare legislation. But Mr. Kennedy realizes any gain would go against the historical trend in off-year elections, that his own popularity is declining, according to the pollsters, while GOP hopes are rising, and that no less than 21 Senators of his own party voted against his medicare plan.

Consequently he plans to campaign especially in genuine two-party "swing" areas, harping on the theme of Republican "destructionism" on everything he wants, from more public works to medicare.

How exciting people find the President's domestic programs is another question. Certainly the record on Capitol Hill does not suggest that the members of Congress have detected any thunderous groundswell for them. And it would be a little surprising if there were, since most of the proposals have the tired air of the Thirties about them, hardly even touched up.

In all this, we think, is an opportunity for an opposition party, if the Republicans concede they are that, to make a forceful case for a different approach. It is not enough to promise the same things with slight modifications.

The real answer to compulsory Social-Security medical insurance for the aged is the rapidly growing voluntary insurance plus public assistance where truly needed. The only real answer to the farm problem is not the Administration's proposed regimentation but a gradual return to a free market.

There is much more. It stands to reason that the key to greater economic growth is not expansion of the Government but expansion of the economy. The Government has demonstrated over the years that all its spending and deficits and controls cannot prevent or cure recessions, much less produce a major advance in sound economic growth.

The proper Federal function is to create the climate in which the economy can flourish. That primarily requires lessening the pressure the Government exerts on the economy through excessive spending and regulation.

The Republicans have often been timorous about making that case. But they should be able to remember that the idea of freedom from Government, so long applied in this country, is the most dynamic idea in political history. It ought to be worth a try as a political program in opposition to the dreary doctrine of Government expansion and compulsion.

What needs to be anchored down is the Government itself, precisely so that free men can sail.

Wall Street Journal, July 25, 1962.

MANAGEMENT OF THE DONOR SITE: A NEW DRESSING TECHNIC*

P. C. Shea, Jr., M.D., *Atlanta*

■ *Forty-seven patients had donor sites treated by this method*

THE MOST IMPORTANT GOAL of donor site care is rapid re-epithelialization with a minimum of discomfort. In recent years, continued evaluation of methods has resulted in increasingly more satisfactory techniques. Proper healing is best achieved by (1) prevention of excessive blood loss, (2) avoidance of a moist wound, (3) reduction of bacterial proliferation, (4) maintaining minimal wound mobility, and (5) minimizing after-care. Most favorable results have been obtained by employing a combined dressing technic presented here. Oxidized regenerated cellulose is applied to the freshly cut donor site and a non-adherent rayon dressing is superimposed and sutured in place. In addition, a conventional, soft, bulky dressing is also added.

Material

Oxidized regenerated cellulose¹ is a synthetic cellulose fiber of uniform diameter and chemical composition made by the viscose process. The true chemical compound formed (polyanhydro-glucuronic acid) has shown marked specific hemostatic properties and is readily soluble in weak alkalis. In addition, through a process of further oxidation, the body is able to degrade the molecule by enzymatic systems which normally hydrolyze carbohydrates. Therefore, the material is readily absorbable. It is utilized as a surgical dressing in the form of a fine mesh, knitted, gauze-like fabric.

The non-adherent rayon dressing used in this study has previously been described.² It is a rayon filament knit into fabric mesh whose openings are large enough to permit drainage into a secondary

dressing. The rayon is impregnated with an emulsion which is confined to the threads, making them non-adherent and does not block the openings. This material is strong enough to be sutured in place with any conventional suture material.

Method

Immediately after excision of skin from the donor site, one or two thicknesses of the absorbable hemostatic dressing is laid on the cut surface. It adheres on contact with moisture (blood or serum) to the wound surface, regardless of contour, and can readily be smoothed or tamponaded into position with dry gauze. On contact with blood it becomes first brown, and then black. Initially, drops of blood may exude through the mesh of the hemostatic gauze (Fig. 1). Minimal pressure, after application, increases rapidity of hemostasis. Complete hemostasis is usually effected within four minutes.



Figure 1

Donor site immediately after application of hemostatic gauze and non-adherent rayon mesh.

*Materials furnished by Johnson & Johnson, New Brunswick, N. J.

Non-adherent rayon mesh is then superimposed, stretched tight to conform with surface contour and sutured in place with interrupted 4-0 silk at its edges at intervals of three-quarters to one inch. The rayon dressing can be sutured quickly while awaiting hemostasis and then sponged dry (Fig. 2). Dry, fluffed-out gauze is then added and a superimposed roll of compression-type gauze or elasticized roller bandage forms the outer support. This entire dressing is left undisturbed for twelve days, and then completely removed (Figs. 3, 4).

Forty-seven patients had donor sites treated by this method. Donor sites varied in thickness from twelve to fourteen-thousandths of an inch, more frequently the latter. Only rarely were thicker grafts obtained. In ten, staged grafting procedures were done; therefore, multiple sites were utilized.

In seven burn patients, exuberant, boggy, and severely infected granulation tissue was excised and dressed in a manner identical to that used in the donor sites. Delayed grafting of skin was performed later.

In three patients, the dressing was used to cover the bed of a freshly excised stasis ulcer.



Figure 2
Same as Figure 1 — four minutes later.

Results

In the group of 47 patients whose donor sites were treated with this dressing, 29 (62%) achieved complete healing of the donor area at the time of dressing change 12 days after surgery (Figs. 5, 6). An additional eight (17%) were almost completely healed. These latter demonstrated lack of complete epithelialization in an occasional area less than one cm. in diameter and had healed 95 per cent or more of their surface area. Seven (15%) had three-fourths or more of the surface area healed. Only three (6%) were considered as unsatisfactory. Two of these had re-epithelialized over one-half the area involved. The

third was a donor area cut twenty-thousandths of an inch in thickness and demonstrated expected delayed healing. In the latter, donor sites were healed 30 days after surgery without additional treatment other than occasional dressing changes.

A few patients exhibited discomfort when dressings were removed. As with many children, this was frequently associated with removal of the "tacking" sutures. In 12 days, the absorbable hemostatic mesh on the donor site had disappeared and the rayon dressing was removed almost painlessly.



Figure 3
Donor site during process of dressing removal on the 11th post-operative day.

There were seven patients, with delayed healing after thermal burns, who presented themselves with exuberant, boggy, and infected granulating areas which bled freely. These were sharply excised down to firm subcutaneous structures and the resulting wound dressing performed in the same fashion as for donor sites. These dressings were left in place for seven or eight days. When removed, dissolution of the absorbable hemostatic mesh had occurred and the wound uniformly exhibited tight, fine, richly vascularized granulations, ideal for grafting. Grafts applied at this time healed well.



Figure 4
Same site as in Figure 3 — complete removal.



Figures 5 and 6
Healed donor sites. 11th postoperative day.

Three patients with moderately to severely infected, chronic stasis ulcers had excision of the ulcer, surrounding indurated skin, subcutaneous tissue and deep fascia, and were immediately dressed with this technic. Secondary skin grafting procedures, seven to eight days after excision, resulted in complete healing of the grafts in each situation.

Discussion

The stimulus for this study developed from an effort to rehabilitate, as rapidly as possible, a group of children whom it was felt had waited overlong for definitive care. It was a continuing outgrowth of previous studies.² The particular technics herein presented have been utilized for a period of two years and have proved to be satisfactory.

The majority of the patients treated came from a particular strata. An extremely poor socio-economic situation existed and many had experienced their burns two weeks to three months prior to referral to a treatment center. Many of them, because of surface extent and low tolerance, required staged grafting procedures. Several, because of the existence of exuberant, infected granulations, needed surgical debridement prior to grafting. In such patients it is superfluous to discuss the hazards to healing in areas that have been exposed to drainage materials from such wounds. Also, one can readily appreciate why blood loss during operative procedures must be reduced to a minimum.

Artz et al³ in 1955 described a most suitable, inexpensive dressing technic for donor sites. They utilized an exposure method in which a single thickness of fine mesh gauze was applied to the freshly cut donor site. A warm, moist gauze pad was superimposed for hemostasis and then removed at the end of the operation. Cells and serum became enmeshed in the single gauze layer and formed a hard coagulum which functioned as a protective covering. They noted that a few children and some irrational patients pulled at the gauze and loosened it. Their method, they state, is contraindicated in circumferen-

tial donor sites of the legs, upper arms and abdomen.

Anderson et al⁴ experienced dissatisfaction with the use of occlusive dressings for donor sites. They employed a combination method using both occlusive and exposure technics. The donor site was covered with a greased fine mesh gauze and then a superimposed occlusive dressing. The occlusive dressing was removed 12 to 24 hours after surgery, leaving the single layer of greased gauze attached to the raw surface. This was left exposed, and a thin pliable coagulum formed. The occlusive dressing could be removed, they stated, with ease, but with some discomfort to the patient.

In the donor sites of this series of 47 patients, the combination of an absorbable hemostatic agent and a non-adherent rayon mesh with a superimposed occlusive dressing has proved to overcome many disadvantages. Hemostasis and the prevention of excessive blood loss is effected within a very few minutes. The resulting dryness avoids maceration due to moisture and as a result, diminishes markedly the opportunity for bacterial proliferation. Wound mobility is reduced by virtue of the rayon mesh being drawn tight and sutured in place, and the additional support is obtained from the added occlusive dressing. The non-adherent rayon also protects the surface from direct contact with the gauze in the occlusive dressing.² Used in this manner, then, re-epithelialization may progress with a minimum amount of interference. The dressing is adaptable to almost any body contour. When donor sites have been at a premium, it has served well even on the dorsum of the foot. During the two-year period in which this study was conducted, environmental temperature and conditions did not influence results. No evidence of toxicity or allergenicity was noted.

Pain was reduced because the dressing was applied during the operative procedure and not removed or altered for 12 days. The rayon mesh is non-adherent, non-hygroscopic, and remains soft and pliable. The occlusive portion protected the wound from the

fingers of children. At removal, the dressings released well. As stated, some of the children, not unexpectedly, complained about the removal of sutures, but otherwise experienced no distress.

Summary

1. A dressing technic for donor sites employing an absorbable hemostatic agent is described.
2. Certain advantages are noted:
 - a) Prevention of excessive blood loss.
 - b) Avoidance of a moist wound.
 - c) Reduction of bacterial proliferation.
 - d) Minimization of after-care.
 - e) Reduction of mobility, allowing more effective re-epithelialization.

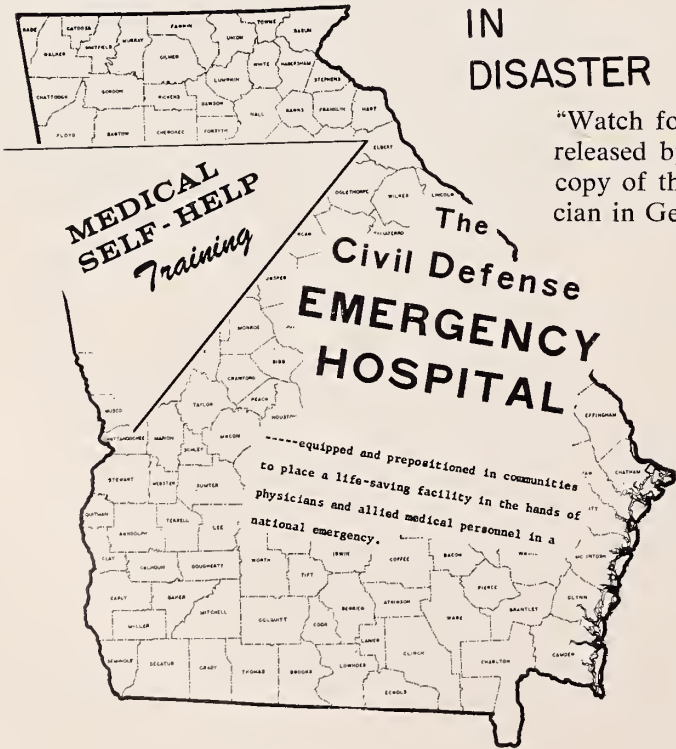
Medical Arts Building

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MEDICAL AID TO GEORGIANS IN DISASTER

MEDICAL
AID TO
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"Watch for this. This is the front cover of a pamphlet released by your Disaster Medical Care Committee. A copy of the pamphlet will be distributed to each physician in Georgia. Keep it for future reference."

CLINICAL EVALUATION OF SODIUM D-THYROXINE IN THE THERAPY OF HYPERCHOLESTEROLEMIA

Lamar B. Peacock, M.D., *Atlanta*

■ **One may expect a reduction in blood cholesterol levels of about 25 per cent in patients treated with sodium Dextro-thyroxine**

FOR MANY YEARS it has been known that the thyroid gland plays an important role in cholesterol metabolism. It lowers serum cholesterol levels in overactive thyroid states and elevates cholesterol levels in hypoactive state.^{1,2}

Because hypercholesterolemia predisposes an individual toward atherosclerosis,^{3,4,5,6,7} it was logical to use thyroxine in an attempt to normalize the serum cholesterol content. Thyroxine proved excellent in hypothyroid disease and was also effective in many euthyroid patients. It acted by increasing liver catabolism and the excretion of cholesterol in the biliary tract.

Unfortunately, in some euthyroid patients, this cholesteropenic effect was counter-balanced by its calorogenic effect. Anginal patients became worse and other patients developed signs of thyroid overactivity. It was obvious that a thyroxine analogue, maintaining cholesteropenic action but without significant calorogenic effect, was needed.

In 1951 Gross and Leblond⁸ discovered triiodothyronine and the present investigations in thyroxine analogues began. Many such analogues have been produced. Their actions on the biochemical systems involving growth, metamorphosis, lipid metabolism, heat production, and central nervous system activity varied, but most continued to have excessive calorogenic effect. More recently investigation began on the optical isomers of these analogues. One of these, dextro-tri-iodo-thyronine, proved to be effective in lowering cholesterol but, unfortunately, it elevated the basal metabolism mark-

edly.⁹ Investigation with this preparation was discontinued. Another isomer, dextro-thyroxine—hereafter referred to as D-T4—had long been considered to be completely impotent, but Pitt-Rivers and Lerman¹⁰ showed it to have one-tenth the calorogenic activity of thyroxine. Further investigation by Starr and others^{11,12} showed D-T4 to have these properties:

1. It had about one-tenth of the calorogenic action of the levo-isomer by weight.
2. It lowered the serum cholesterol level of the athyreotic patient without raising his basal metabolic rate.
3. It lowered the abnormal serum cholesterol level of the euthyroid patient while maintaining his basal metabolic rate.
4. It could lower serum cholesterol without stimulating the heart in either the athyreotic myxoedematous or euthyroid state whether the heart was normal or pathological.
5. Preliminary evidence suggested that it maintains a normal basal metabolic rate and serum cholesterol without producing angina pectoris in a patient with coronary artery insufficiency.
6. Growth in athyreotic rats is maintained by tenfold dosage as compared to levo-thyroxine.
7. Thyroid-stimulating-hormone (TSH) secretion of the pituitary is depressed to a considerable extent by the administration of D-T4.
8. D-Thyroxine stimulates hepatic oxidative catabolism and excretion of cholesterol and its degradation products via the bile and bowel in the feces.

* Available for this study as CHOLOXIN®, brand of sodium dextro-thyroxine from Baxter Laboratories, Inc., Morton Grove, Illinois, through the helpful assistance of Thomas A. Garrett, M.D., Medical Director.

Presented at American College of Physicians Sectional Meeting, Sea Island, Georgia, September 1961.

9. In addition to the above, the D- and L-forms have different rates of concentration in vital organs and of removal from the blood.
10. The D-form is excreted almost completely in the urine and feces.
11. Toxicologic studies of the D-form in several species of animals in the laboratory indicated that its general safety might be expected in the human.
12. Other endocrine effects, particularly in relation to androgen metabolism, are indicated.

Owen, Owens, and Neely¹³ showed an increased fecal excretion of cholesterol, reduction by an average of 25 per cent of the blood cholesterol, no aggravation of angina by normal doses of the drug, slight potentiation of warfarin sodium anti-prothrombin activity, no significant effects on liver function, and a disappearance of tuberous xanthomatous lesion of the skin with D-T4.

In October 1960, we began to investigate the clinical effectiveness of this drug in hypercholesterolemic individuals. This paper presents the results of our study of 50 patients, many of whom have been on this drug for 14 months.

Method

For this study 50 patients were selected at random from individuals undergoing routine medical evaluation in our office. The reason for their selection was based solely on the laboratory evidence of hypercholesterolemia characterized by serum levels above 275 mg. per cent. Many of the patients were otherwise asymptomatic. However, approximately 16 had arteriosclerotic heart disease and three had diabetes.

Cholesterol levels were checked routinely on fasting serum prior to the administration of the drug. Some patients selected had been under our care for many years. For 20 years cholesterol levels had been run almost routinely for their yearly health examinations; thus, in some cases, a large backlog of cholesterol values was available. The cholesterol method was that of Lieberman-Burchard.¹⁴

Patients were started on D-T4 at a dosage of one 4 mg. tablet each morning.* No patient was advised to restrict his diet, although seven had previously been on fat restriction. Attempts were made to obtain cholesterol levels approximately every four weeks. No changes were made in the patient's activity or habits.

Results

A marked reduction of 20 per cent or more was noted in the serum cholesterol of 30 patients (60%)

at the completion of our study. In 16 patients (32%) a mild to moderate reduction was seen. Only four patients (8%) showed a slight reduction of ten per cent or less. The average serum cholesterol level was 399 mg. per cent before treatment was begun. At the end of the study, the average serum cholesterol level was 261 mg. per cent—a reduction of 78 mg. per cent, or a total percentage decrease of 23 per cent.

Figure 1
EFFECT OF THERAPY ON CHOLESTEROL LEVELS

Serum Cholesterol Level	Before Therapy	After Therapy
200 mg. % or above	50 pts. (100%)	46 pts. (92%)
250 mg. % or above	50 (100%)	27 (54%)
300 mg. % or above	41 (82%)	9 (18%)
400 mg. % or above	5 (10%)	1 (2%)

D-T4 was administered on a regimen of 4 mg. daily to 45 patients. Five patients received 8 mg. daily. Of this second group, one patient received 12 mg. daily briefly, but since the cholesterol level did not drop further, the dosage was reduced to 8 mg. Particular attention was given to the incidence of side effects, especially any evidence of calorigenesis. No electrocardiographic evidence of cardiac change was seen in our study. Although three of our patients had had coronary attacks prior to therapy, none of our arteriosclerotic heart disease patients have had a coronary attack since treatment with sodium dextro-thyroxine began. There were no significant changes in either the blood pressure or the pulse rate of any of our patients. Ten of our patients had a history of angina pectoris. Of these, nine had no change in either the incidence or the severity of their attacks, while in only one was there an increase, and this was questionable.

Figure 2

DIAGNOSES OF PATIENTS WITH HYPERCHOLESTEROLEMIA

Diagnoses:	No. Pts.
Hypercholesterolemia without apparent etiology and without apparent complications (idiopathic hypercholesterolemia?)	26(52%)
Arteriosclerotic heart disease	16(32%)
Definitely Hypothyroid or with probable Thyroid pathology (Definite 3, Questionable 4)	7(14%)
Atherosclerosis (generalized?)	3(6%)
Diabetic or Prediabetic	3(6%)

The total is larger than 50 (or 100%) because a few patients had multiple diagnoses, e.g., A.S.H.D. with hypothyroidism.

Discussion

Atherosclerosis is one of the major killers in the world today. Recognized as a specific disease and one in which there is a faint hope of reversibility, its etiology is believed to be multiple and multifaceted. Among the possible etiological factors contributing to atherosclerosis are heredity, diet, elevated serum lipids, hypertension, emotional stress situations, the aging process, obesity, hormone imbalance, vascular trauma, excessive smoking habits, sex differences,

physical activity, liver function, infection, and cultural habits.

Lipoid metabolic disturbance is recognized as one of these contributing factors.^{15,16,17} There are four main classes of lipids.¹⁸ Triglycerides contain glycerol in combination with three fatty acids. Phospholipids consist of a fatty acid, a phosphate radical, and a nitrogenous base. The third group, sterols, occur either as free sterols, esterified with fatty acids, cholesterol (from animal fats), or sitosterol (from plant fats). Free or non-esterified fatty acids are the fourth group of lipids.

Cholesterol is only one fraction of total blood serum lipids. It is transported as beta lipoprotein in Svedberg flotation units 0-400, more being present in the 0-12 or denser areas, less in the 12-20 levels, and least in the 20-400 Svedberg flotation units. The level of cholesterol does not coincide directly with atherosclerosis in the patient clinically, nor do any other of the fat fractions. As mentioned before, hypercholesterolemia does predispose^{3,7} the patient toward atherosclerosis. It is one contributing factor, whether acting directly or indirectly, in causing atherosclerosis. The blood level of cholesterol is the result of ingestion of cholesterol in food, plus synthesis within the body, less the degradation by the liver and elimination of cholesterol via the biliary tract. Some cholesterol is reabsorbed from the intestinal tract along with the bile acids. Thus there is an enterohepatic cycle, another factor to consider in cholesterol metabolism.

The average serum cholesterol of middle age American males is 240 mg. per cent. Kinsell¹⁹ suggested a desirable level of 180 mg. per cent. Olson²⁰ selected 200 mg. per cent and findings in the Framingham study suggested a satisfactory level of 225 mg. per cent.

Effect Unknown

It is not precisely known what effect cholesterol lowering will have on atherogenesis. As Moses states, "the prevention of atherosclerosis is not synonymous with the control of hypercholesterolemia."²¹ Yet the answer must be obtained. Many regimens have been used to accomplish a low blood cholesterol. Diets have been used and are still being formulated. Their value is unknown, but many articles cite their effectiveness. The chief objection is that few patients will follow them for any length of time and, therefore, their effectiveness is limited. In dieting there is still the question of whether unsaturated fats versus saturated fats provide lowering of cholesterol and thereby assist in preventing atherosclerosis. This is a point not yet thoroughly evaluated. The sitosterols have been tried, popularized, and yet found lacking in

their ultimate effect due to a highly variable end result.²²

Drug therapy is a more satisfactory solution on the part of the patient, provided the dosage frequency and cost can be made suitable.

Nicotinic acid and related salts are now in use, but large doses are needed (3 to 6 grams) and side effects such as flushing, pruritis, gastric irritation, jaundice,²³ peptic ulcer activation,²⁴ the appearance of diabetes mellitus, and abnormal liver function²⁵ have detracted from its usefulness.

Controversy

Heparin is known as the lipid mobilizing factor or LMF. Heparin activates a lipoprotein lipase or clearing factor which promotes the removal of dietary fats and other lipids from the serum. There is much controversy as to its efficacy in the prevention of atherosclerosis. There are also inherent dangers in the anti-thrombin activity of the drug which tend to limit its usefulness. Another problem is the fact that heparin must be given by hypodermic injection since its sublingual activity is not adequate.

The estrogens are thought to protect against atherosclerosis. They are known to depress the cholesterol levels. Their drawback has been the production of side effects such as gynecomastia in males and the suppression of libido. These symptoms have precluded their use by most physicians in clinical practice, although newer estrogen products offer some hope of effectiveness as cholesterol-lowering agents without these side effects.²⁶

Triparanol is a potent inhibitor of cholesterol production, blocking just prior to synthesis. Studies indicate that large amounts of the resulting product, desmosterol, accumulate in the body. While numerous reports attest to its cholesterol-lowering effect, there is still the unanswered question as to whether desmosterol is atherogenic. In addition, side effects of ichthyosis, loss of hair,^{27,28} reduction in corticosteroid output,²⁹ positive SGOT and cephalin flocculation tests,³⁰ and loss of libido have been reported. In our own practice we have found that many patients will escape from control by this drug within three to four months.

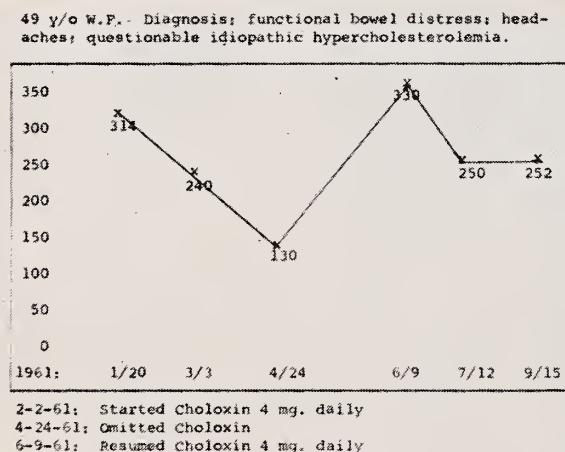
A more logical approach would seem to be the physiological one of eliminating excessive cholesterol through its normal channels. That is, 1) by the degradation of cholesterol into bile acids and, 2) through elimination of cholesterol and bile acids via the biliary ducts into the small intestine. This would merely increase a normal activity of the body and would be as effective on cholesterol levels, whether being maintained through diet or excessive synthesis. Thyroxine answers this approach except for its calorigenic effect. Since most patients now in need of

treatment of atherosclerosis cannot tolerate this basal metabolic increase, D-T4 may now provide an answer to the problem. It lowers serum beta-lipoprotein cholesterol. It has little or no effect on either triglycerides or phospholipids. This may prove detrimental, for some research has suggested a close tie-in between the levels of triglycerides and the amount of atherosclerosis.³¹

Side effects have been confined to reports of increased angina,²¹ but there are other reports of decrease or loss of anginal symptoms.³² No electrocardiographic changes have been reported. Davis et al¹² noted no metabolic changes on patients, when up to 16 mg. per day or four tablets per day were given. This is four times the recommended dosage of D-T4. Prolongation of prothrombin times, when the patient is on anti-prothrombin drugs, has been noted.¹³ It should be observed closely in patients on D-T4. Prolonged prothrombin time presents no problem, since simple reduction of anti-prothrombin drugs resolves the difficulty. This problem has not occurred in our experience up to this time.

Response to D-T4 occurs in approximately one to four weeks, with relapse in one to two weeks if the drug is discontinued. Re-institution of the drug produces a second drop in cholesterol levels. This is clearly shown in Figure 3.

Figure 3



The patient, a white female of 49 years, was under treatment for functional bowel distress, accompanied by headaches and hypercholesterolemia. One month after sodium dextro-thyroxine 4 mg. daily therapy began, her serum cholesterol was within normal limits, having dropped 22 per cent from its previously elevated level. Her serum cholesterol level continued to decrease the next seven weeks until it reached 130 mg. per cent and therapy was discontinued. Six weeks later her serum cholesterol was checked, and it was discovered that her serum cho-

lesterol level had risen to 330 mg. per cent. D-T4 therapy was resumed at the former dosage regimen and during the next three months the patient's serum cholesterol level was readjusted to within normal limits. This response of serum cholesterol is so accurate that it is possible to check on a patient as to whether he has been following instructions in taking the drug properly.

Most articles have mentioned the failure of the patient to escape from the activity of the drug. There are now several papers going to press, covering a year's treatment with the drug, and the activity of D-T4 is well maintained over this period of time. It should be mentioned that the protein bound iodide levels can be expected to increase with the administration of this drug. This will not mean that the basal metabolic rate is increased. On normal dosage the protein bound iodide may increase approximately eight to ten micrograms per cent.

Practicing physicians may expect a drop of approximately 25 per cent in blood levels of cholesterol on the average patient. Greater drops will occur in patients with higher levels of cholesterol. The drug is a very effective hypercholesterolemic agent, and it can be used safely in the vast majority of patients, even those with arteriosclerotic heart disease. In patients with angina it should be used with care.

Dextro-thyroxine therapy represents a step toward the solution of the problem of atherogenesis. Perhaps we may offer some hope to patients with atherosclerosis—not only hope of preventing the progression of the disease, but even the very faint hope of reversal. Only time will give the final answer.

Summary

Fifty patients including 16 with arteriosclerotic heart disease have been treated with dextro-rotary thyroxine, an experimental drug retaining the ability of thyroxine to lower the serum cholesterol but having only one-tenth the calorogenic action of the levo-isomer by weight. In 32 per cent, a mild to moderate drop in cholesterol values was noted and 60 per cent had a marked drop; only eight per cent showed slight to no drop. Side effects in the dosage administered have been practically nil. The only significant side effect noted was a possible increase in angina in one patient; however, the drug was not discontinued and has been maintained in this individual without difficulty. Slight potentiation of anti-prothrombin drugs has been reported. Dextro-thyroxine will provide a new and valuable tool in the treatment of atherosclerosis. Its precise role in the prevention of atherogenesis is yet to be established.

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GEORGIA MEDICAL BOARD APPROVES 41 SCHOLARSHIPS

The State Medical Education Board, which has just completed its ninth successful year of operation, has approved scholarships for 38 white and three Negro medical students.

At the same time, the board renewed the scholarships for 91 medical students now attending medical schools.

More than 30 new scholarships are granted by the board each year to bona fide residents of Georgia who wish to attend accredited medical schools. There will be 132 students attending such schools on scholarships from the board during the 1962-63 school year.

The scholarships amount to \$1,250 a year. The medical student, after he becomes a doctor, may re-

pay his scholarship by practicing in a rural community with a population of 5,000 or less for one year for each \$1,000 he received under the scholarship.

This assures a flow of doctors into the smaller communities each year, even though some of them later move on to the larger cities. For example, as of July 1 this year, 77 doctors who had been financially assisted through medical school by the board were practicing in such smaller communities as Dah-longa, Blairsville, Jefferson, Loganville, Sylvania, Lavonia, Guyton, Port Wentworth, McDonough, Warrenton, Waynesboro, Arlington, Clarkesville, Jackson, Sandersville, Gordon, Harlem, Wrightsville, Eastman, Hiawassee, Clayton, Jesup, Bowdon, Dawson, Pearson, Woodstock, Newnan and other towns.

TOTAL RECONSTRUCTION OF THE THUMB, THE ROLE OF DIGITAL TRANSFER

Carl R. Hartrampf, M.D., *Atlanta*

- **By using this technique, any digit in the hand may serve as the thumb donor**

AMPUTATION OF THE THUMB at any level proximal to the metacarpophalangeal joint is a total functional loss of that digit. Suffice it to say, the disability accompanying such an injury is considerable. Without a thumb as an opposable digit, the hand is useful only as a sensitive hook. In an effort to create some prehensile mechanism, the thumbless hand makes compensatory adjustments, usually between the index and long fingers. However, considering that the oppositional thumb is one of the distinguishing evolutionary refinements of man, it is noted that by adapting to the flat hand, as with loss of the thumb, man is reverting back to the crude, less efficient hand of the lower primates. With present-day knowledge in thumb restoration, such a hand is not acceptable.

Subtotal reconstruction of the thumb is a subject of its own and will not be discussed here. The procedures for total reconstruction of the thumb can be divided into the following categories:

Tubed Pedicle Flap Stabilized with a Bone Graft

This is one of the oldest methods of reconstruction and has produced many fairly satisfactory thumbs. However, the procedure has a number of disadvantages. First, it is a multistaged procedure, requiring many months before final completion. Very often, after enduring the rigors of many operations, the patient is left with a "stake," which is prone to injury, immobile and insensitive. Absorption of the stabilizing bone is not an infrequent complication. Dr. Littler's technique of providing sensitive skin to the tactile pad of the new thumb, by the island pedicle method, has given this procedure new life.² However, even with the addition of sensitive skin, the other drawbacks persist and generally, the method lacks the many advantages of digital transfer.

Toe Transfer or Transfer of a Digit from Opposite Hand

The technique of transferring the great toe to the thumb position was first described over 50 years ago. Today, with other methods available, this technique must be regarded as a surgical stunt. The patient must maintain the awkward hand-to-foot position for a prolonged period. The thumb so produced must derive its nourishment and sensation through a ring of dense scar which carries through all layers, including bone, and it is likely that both blood supply and nerve supply will be deficient. The same objections can be raised to the transfer of a digit from the opposite hand.

Digital Transposition

Bunnell, in 1929, transferred the index finger to the stump of an amputated thumb by means of the two neurovascular bundles, the flexor and extensor tendons, as well as a dorsal skin bridge.¹ Littler and Peacock have, in the last decade and a half, perfected the neurovascular transfer of the index finger to the thumb position.³ This procedure is performed in one stage, requiring from two, to two and one-half hours for completion. Bone consolidation is usually complete in eight to ten weeks, and then the patient may return to work. The thumb so created has as many of the characteristics of a normal thumb as can be obtained from a reconstructive procedure. The new thumb has two active joints, controlled by the balance of a normal thumb flexor and extensor mechanism. The tactile pad has normal stereognosis. The appearance is quite satisfactory (Figure). Using the neurovascular transfer method of reconstruction, any digit in the hand can serve as the thumb donor. If there is a damaged digit, this would be the one to

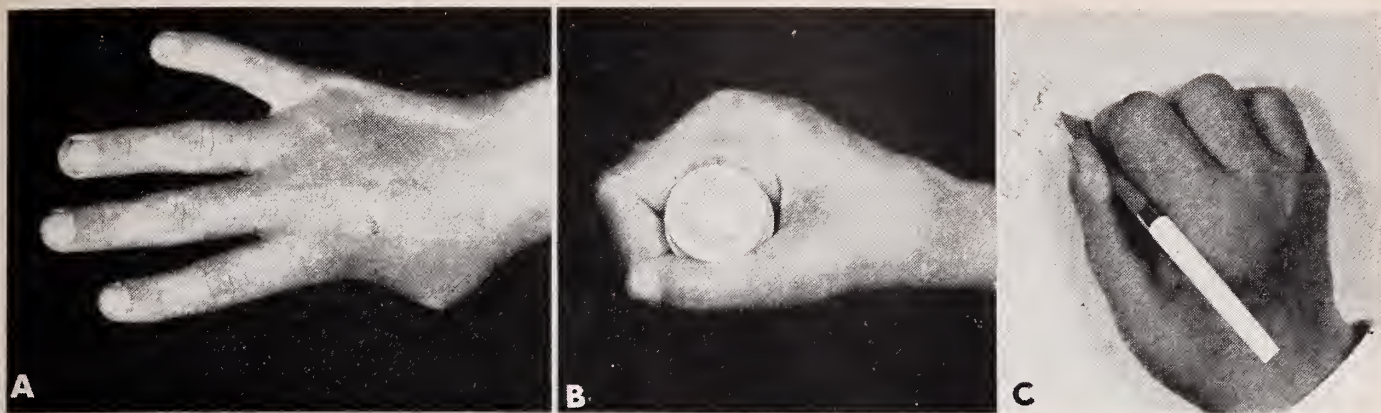


Figure
A, preoperative view of amputation. B and C, after pollicization of the index finger.

transfer. If the long or ring finger is used, the donor space may be closed and symmetry restored by transferring over the adjacent digit, as described by Peacock.⁴

In the past, critics of the digital transfer technique have voiced their objection to the sacrifice of a normal finger to restore the thumb. First, they fear loss of the donor digit from the trauma of surgery. However, experience has proved this to be only a theoretical disadvantage. Many fingers have been transferred by a single vascular bundle without loss of tissue. Next, they object to the possible cosmetic effect of reducing the number of fingers on the hand. In actuality, people do not count fingers, they count nubs and spaces. The hand, after pollicization, has none of these. It is a symmetrical, well-balanced hand that does not attract attention.

Summary

In summary, thumb reconstruction by digital transposition, using the neurovascular transfer method, is a reliable and a highly satisfactory procedure. The predictable success of this method, brought about by refinements over the past few years, now makes it the procedure of choice in total reconstruction of the thumb.

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CYANOSIS IN PREMATURE AND NEWBORN INFANTS

The Subcommittee on Accidental Poisoning of the American Academy of Pediatrics is alerting Fellows of the Academy to the possibility of a new chemical cause of unexplained cyanosis in infants due to methemoglobinemia.

As a result of investigations launched three weeks ago by Benjamin A. Kagan, M.D., it is believed likely that autoclaving diapers that have been rinsed with a bacteriostatic chemical called "TCC" (3-4-4 trichlorocarb-anilide) can cause degradation of this chemical to chloranilines which in turn, through skin absorption, may produce sufficient methemoglobinemia to result in clinical cyanosis and anemia. Thus far there have been about 18 cases detected from three hospitals throughout

the United States. Although there have been no fatalities and it cannot be stated with absolute certainty that "TCC" is the only causative agent, because of the probability involved, the manufacturer has advised the formulators of products incorporating "TCC" in their rinses to withdraw them from the market.

If unexplained cyanosis occurs in infants whose diapers have been autoclaved (boiling is *insufficient* to cause degradation to chloranilines), the Subcommittee suggests checking to see if "TCC" or any formulations containing it, have recently been added to any of the soap, detergent, or sanitizing chemicals used in the laundering process.

Edward Press, M.D., Chairman
Subcommittee on Accidental Poisoning

blood pressure approaches normal more readily, more safely....simply with **Salutensin**[®] (hydroflumethiazide, reserpine, protoveratrine A—antihypertensive formulation)

Early, efficient reduction of blood pressure. Only Salutensin combines the advantages of protoveratrine A ("the most physiologic, hemodynamic reversal of hypertension"¹) with the basic benefits of thiazide-rauwolfia therapy. The potentiating/additive effects of these agents²⁻⁸ provide increased antihypertensive control at dosage levels which reduce the incidence and severity of unwanted effects.

Salutensin combines Saluron[®] (hydroflumethiazide), a more effective 'dry weight' diuretic which produces up to 60% greater excretion of sodium than does chlorothiazide⁹; reserpine, to block excessive pressor responses and relieve anxiety; and protoveratrine A, which relieves arteriolar constriction and reduces peripheral resistance through its action on the blood pressure reflex receptors in the carotid sinus.

Added advantages for long-term or difficult patients. Salutensin will reduce blood pressure (both systolic and diastolic) to normal or near-normal levels, and maintain it there, in the great majority of cases. Patients on thiazide/rauwolfia therapy often experience further improvement when transferred to Salutensin. Further, therapy with Salutensin is both economical and convenient.

Each Salutensin tablet contains: 50 mg. Saluron[®] (hydroflumethiazide), 0.125 mg. reserpine, and 0.2 mg. protoveratrine A. See Official Package Circular for complete information on dosage, side effects and precautions.

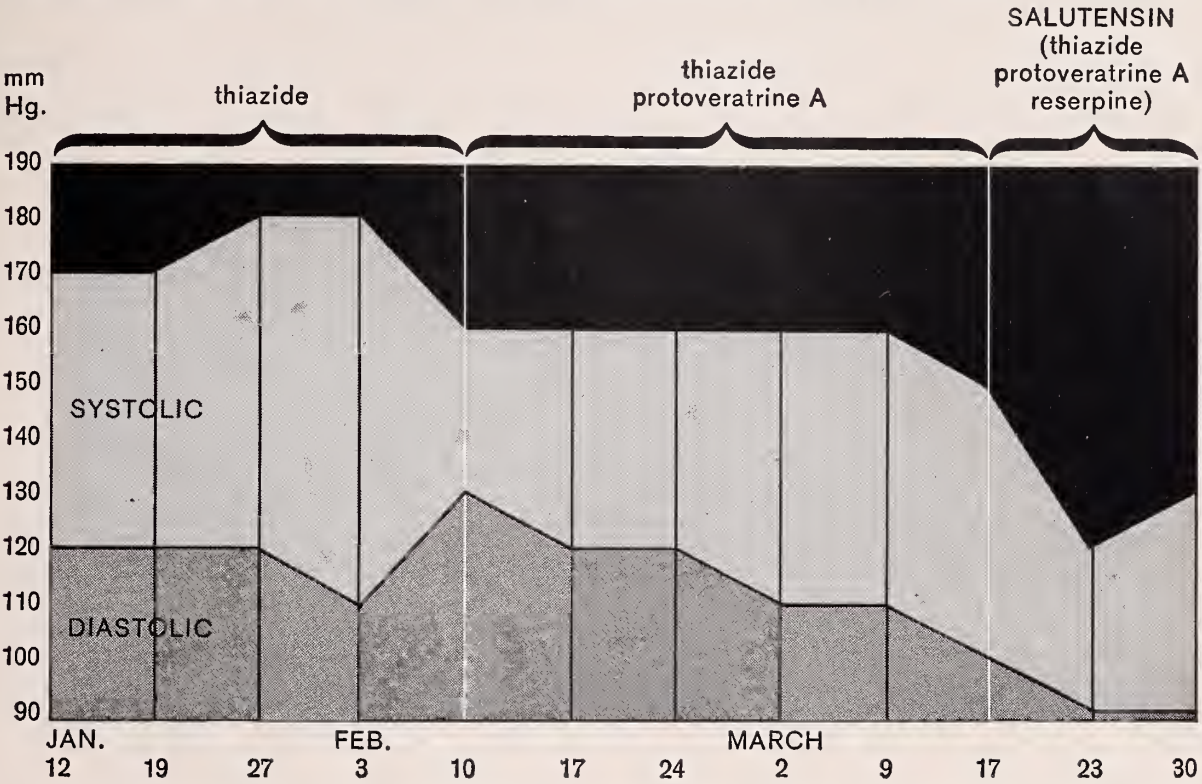
Supplied: Bottles of 60 scored tablets.

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all the antihypertensive benefits of thiazide-rauwolfia therapy plus the specific, physiologic vasodilation of protoveratrine A

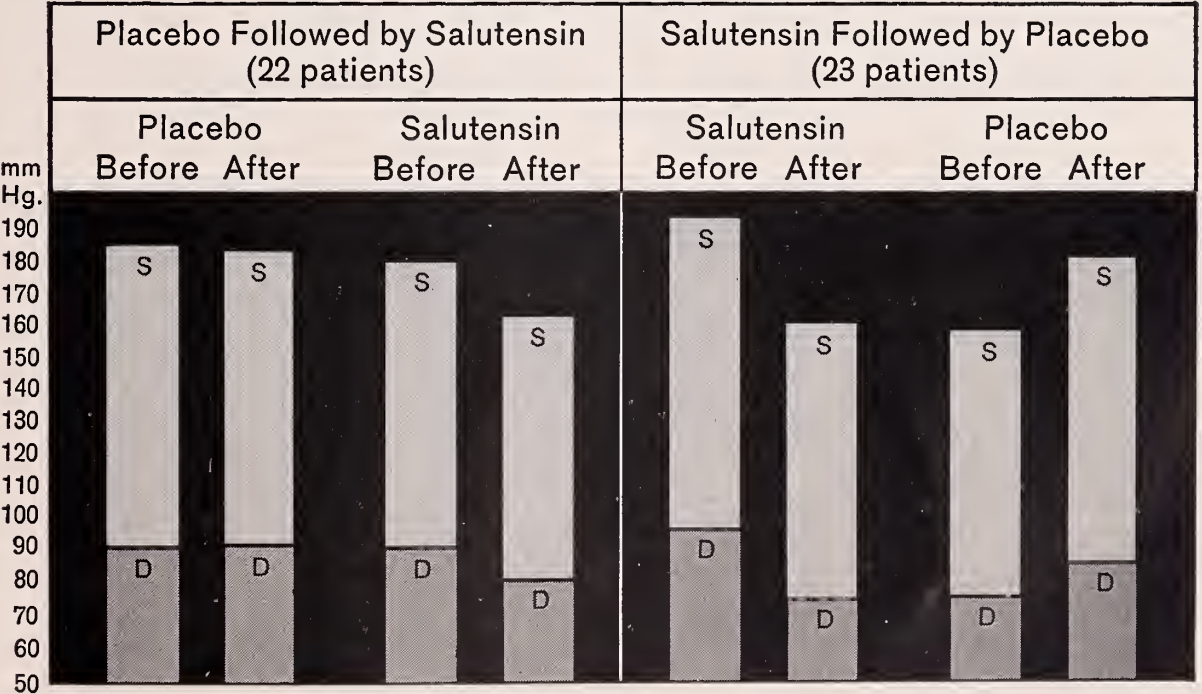
11 WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS BY SERIAL ADDITION OF THE INGREDIENTS IN SALUTENSIN IN A TEST CASE

(Adapted from Spiotta, E. J.: Report to Department of Clinical Investigation, Bristol Laboratories)



3½ WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS USING SALUTENSIN FROM THE START OF THERAPY IN A “DOUBLE BLIND” CROSSOVER STUDY

Mean Blood Pressures—Systolic (S) and Diastolic (D)



In this “double blind” crossover study of 45 patients, the mean systolic and diastolic blood pressures were essentially unchanged or rose during placebo administration, and decreased markedly during the 25 days of Salutensin therapy. (Smith, C. W.: Report to Department of Clinical Investigation, Bristol Laboratories.)

BRISTOL LABORATORIES/Div. of Bristol-Myers Co., Syracuse, N.Y.



1962-63 CALENDAR OF MEETINGS

State

- October 23, 1962-March 14, 1963—Series of Postgraduate Courses presented by the Medical College of Georgia's Department of Continuing Education; October 23-25—"Clinical Pathology in Medical Practice;" November 13-15—"Diagnosis and Practical Management of Arthritis."
- October 25-27—14th Annual Session of the Georgia Academy of General Practice, Atlanta Americana Motor Hotel, Atlanta.
- October 31-November 3—American Society of Tropical Medicine and Hygiene, Atlanta Biltmore Hotel, Atlanta.
- November 29-30—Fourth Annual Postgraduate Course in Ophthalmology of the Emory University School of Medicine, Grady Memorial Hospital, Atlanta.
- February 17-20, 1963—Atlanta Graduate Medical Assembly, Atlanta Biltmore Hotel, Atlanta.

Regional

- September 18-20—Kentucky State Medical Association, Brown Hotel, Louisville, Ky.
- September 19-20—Piedmont Postgraduate Clinical Assembly, Clemson House Hotel, Clemson, S. C.
- September 21-22—American College of Obstetricians and Gynecologists, District VII, Little Rock, Ark.
- September 24-25—Tennessee Valley Medical Assembly, Chattanooga, Tenn.
- September 24-27—American Psychiatric Association, Mental Hospital Institute, Americana Hotel, Bal Harbour, Fla.
- September 27-28—Symposium on Birth Defects, The National Foundation-March of Dimes and Vanderbilt University School of Medicine, Vanderbilt Law School Auditorium, Nashville, Tenn.
- September 30-October 2—Fifth Annual Medical Progress Assembly, Birmingham, Ala.
- October 2-5—American Roentgen Ray Society, Shoreham Hotel, Washington, D. C.
- October 4-6—American College of Obstetricians and Gynecologists, District IV, Barringer Hotel, Charlotte, N. C.
- October 14-17—Medical Society of Virginia, Sheraton-Park Hotel, Washington, D. C.
- October 15-17—The Medical Society of the District of Columbia Second Interstate Assembly with the Medical Society of Virginia, Sheraton-Park Hotel, Washington, D. C.
- October 17-18—American College of Preventive Medicine, Inc., Hotel Fountainebleau, Miami Beach, Fla.
- October 19-21—13th Annual Scientific Assembly, Florida Academy of General Practice, Deauville Hotel, Miami Beach, Fla.
- October 29-31—American Association for the Surgery of Trauma, The Homestead, Hot Springs, Va.
- November 9-10—Southern Society for Pediatric Research, Gainesville, Fla.
- November 12-14—Association of Military Surgeons, 69th Annual Meeting, Mayflower Hotel, Washington, D. C.

- November 12-15—Southern Medical Association, Hotel Fountainebleau, Miami Beach, Fla.
- November 14—Medical Society of the District of Columbia, Washington, D. C.
- November 15-17—Southeastern States Cancer Seminar, George Washington Hotel, West Palm Beach, Fla.
- January 20-25, 1963—American Academy of Orthopaedic Surgeons, Americana Hotel, Bal Harbour, Miami Beach, Fla.

National

- October 4-6—American Medical Association First National Congress on Mental Illness and Health, Palmer House, Chicago, Ill.
- October 4-6—Clinical Orthopaedic Society, Inc., Hotel Statler, Detroit, Mich.
- October 15-19—American College of Surgeons, Clinical Congress, Atlantic City, N. J.
- October 17—Society for Adolescent Psychiatry, New York City.
- October 20-26—Annual Otolaryngologic Assembly, postgraduate course, University of Illinois College of Medicine, Chicago, Ill.
- October 21-26—American Society of Anesthesiologists, Inc., Statler Hilton Hotel, New York City.
- October 22-23—American Cancer Society, Biltmore Hotel, New York City.
- October 22-26—American College of Chest Physicians, postgraduate course, Clinical Cardiopulmonary Physiology, Knickerbocker Hotel, Chicago, Ill.
- October 26-30—American Heart Association, Inc., Sheraton-Cleveland Hotel, Cleveland, Ohio.
- October 27-November 1—American Academy of Pediatrics, Palmer House, Chicago, Ill.
- October 28-31—American College of Gastroenterology, The Morrison, Chicago, Ill.
- October 31-November 3—Congress of Neurological Surgeons, Shamrock Hilton Hotel, Houston, Tex.
- November 1-2—American Rhinologic Society Annual Meeting, Statler Hilton Hotel, Los Angeles, Calif.
- November 3-4—State Medical Editors Conference (fourth), Denver Hilton Hotel, Denver, Colo.
- November 4-9—American Academy of Ophthalmology and Otolaryngology, Las Vegas Convention Center, Las Vegas, Nev.
- November 9-13—American Otorhinologic Society for Plastic Surgery, Inc., Ambassador Hotel, Los Angeles, Calif.
- November 15-17—Southern Thoracic Surgical Association, Arawak Hotel, Ocho Rios, Jamaica, B.W.I.
- November 24-25—American College of Chest Physicians, Annual Interim Session, Ambassador Hotel, Los Angeles, Calif.
- November 25-28—American Medical Association, Clinical Meeting, Los Angeles, Calif.**
- December 1-6—American Academy of Dermatology, Inc., Palmer House, Chicago, Ill.
- June 16-20, 1963—AMA Annual Meeting, Atlantic City, N. J.

1963 Annual Session

May 5-8, 1963 — Aquarama, Jekyll Island, Georgia



First Call for Scientific Papers

All titles must be submitted to the
respective program chairmen listed
below before November 1, 1962

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Bert H. Ellis, M.D.
3043 Sherwood Drive, Brunswick

MEDICINE

Arthur M. Knight, Jr., M.D.
P. O. Box 899, Waycross

PEDIATRICS

Newell M. Hamilton, M.D.
2001 Gloucester Street, Brunswick

CHEST

John A. Hightower, M.D.
2601 Parkwood Drive, Brunswick

OBSTETRICS AND GYNECOLOGY

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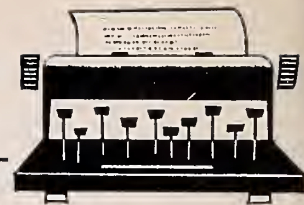
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UROLOGY

Woodrow W. Payne, M.D.
Masonic Building, Brunswick



Regulation of Ovarian Activity

OVARIAN FUNCTION is the axis around which all reproductive activities revolve. No one, in any time or walk of life, is free of its influence. In spite of this, relatively little attention has been given to the methods of controlling this tiny organ.

Only within the past few years has the search been intensified for ways of influencing directly the ovary. The major stimulus for this new interest has come, not from a concern over the common menstrual disorders as one might expect, but from another problem—fertility. In view of the resulting advances, it is well to consider some of those conditions which may respond favorably to ovarian control.

In general, two kinds of malfunction can be recognized. The first, in which maturation of normal ova occurs infrequently or not at all, is often associated with infertility but can also result in menstrual abnormalities. These usually take the form of oligomenorrhea or amenorrhea but are sometimes related to excessive menstrual flow. Studies such as basal temperature determination, ferning of the cervical mucous, and endometrial biopsy fail to show evidence of progestation activity. The second type of malfunction may be difficult to distinguish from this. Here, the events of the ovarian cycle seem incoordinated. Ova may be produced, but the regular rise and fall of the ovarian hormones does not occur. The result is an irregular shedding of endometrium at varied intervals and of differing amounts.

Treatment

Successful treatment of these types of malfunction must result in the maturation of normal ova and a return to the cyclic production of estrogen and progesterone in the proper amounts. It has long been recognized that these effects sometimes follow simple uterine curettage, low dosage irradiation of the ovaries, or correction of abnormalities in other glands, such as the thyroid or adrenal. The mechanisms of these actions are difficult to explain.

More completely understood is the relationship between the gonadotropic secretions of the anterior pituitary and ovarian function. It is known that a follicle stimulating hormone and an interstitial cell stimulating hormone must reach the ovary in the proper sequence and ratio in order to produce the regular maturation of the graafian follicle and formation of the corpus luteum. Preparations capable of bringing about these changes are becoming available, both from human and animal sources. Their efficacy has repeatedly been proven by successful pregnancies. An interesting sidelight has been the formation of several simultaneous corpora lutea and a number of twin pregnancies. More recently, synthetic substances, such as MRL/41 (clomiphene), have also been found to be similarly effective, but their use remains experimental.

Suppression

A discussion of the regulation of ovarian function must also include its suppression. This organ may function so efficiently that too-frequent pregnancies occur to the detriment of both the individual and her society. Many methods and techniques have been used in an effort to keep ova and sperm separated by time and space. Within the past decade, more attention has been given to the actual suppression of formation of the ovum. The ability of estrogen and progesterone to produce this result (probably indirectly through the anterior pituitary) is well recognized and it is this principle which has been widely employed in the "oral contraceptive." It is becoming more and more evident that this is the most practical and efficient system yet devised for use in very large population groups. The long term effects, however, are as yet unknown.

It is, therefore, apparent that with an increased understanding of the anatomy and physiology of the ovary, is coming the means to increase or decrease

its activity. Soon this power will be within the hands of every physician. The results, either good or bad, will reflect the judgement with which it is used.

Earnest M. Curtis, M.D.

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Electronics in Cardiology

ONE OF THE beneficiaries of electronic progress has been clinical medicine. In cardiology there has been particular interest in this field for several reasons, among them the importance of electrical energy in the contraction of the myocardial fibers, and the conduction systems through which this is accomplished. A few of the recent electronic instruments are mentioned below.

The radio wave has been used by Bellet in the modification of the Masters exercise test. A one-lead system utilizing chest electrodes is attached to a miniature radio transmitter on the patient. The lead so taken and transmitted is picked up by a receiver a few feet away as the patient performs the step test and is recorded on the electrocardiogram. Whether the advantage of being able to study cardiac forces during exercise will outweigh the disadvantage of being restricted to one lead remains to be determined. Radio may also be used in monitoring, by transmitting EKG data from the bedside of a patient to a monitoring center, and any interruption of normal rhythm can trigger a warning device.

Electric shock is being used more and more in clinical cardiology. Zoll and others have discussed its use in terminating arrhythmias, some of which are resistant to drug treatment, some, like ventricular fibrillation in which drugs are ineffective or not sufficiently rapid. The triad of countershock, external cardiac massage, and the pacemaker have enabled the cardiologist to revive an occasional moribund patient and to perform procedures which otherwise would carry a prohibitive risk. Coronary angiography can be undertaken, because if ventricular fibrillation results from temporary ischemia, it can be terminated with electric shock while circulation is being maintained by massage, and almost always normal rhythm will shortly re-establish itself with or without aid from the pacemaker. The heart can be stopped for certain procedures with acetyl choline and then be restarted three seconds after arrest by an intracardiac pacemaker in the catheter tip. Obviously there re-

mains considerable risk in such procedures that require careful evaluation of their importance versus the risk involved.

By using sonar type ultrasonics, an estimation can be made of movement of the mitral valve during the cardiac cycle which is said to be helpful in the determination of the degree of mitral stenosis.

Scientists have achieved incredible ability in the miniaturization of complicated instruments. This ability has supplied us with a pressure measuring device small enough to be part of the tip of a cardiac catheter to measure directly the pressure within the cardiac chamber. A miniature pacemaker can be inserted in the abdominal wall of patients with complete heart block with a miniature wire embedded in the myocardium. Miniature pickups have been designed for incorporation in the catheter tip for intracardiac phonocardiography.

Techniques have been perfected for performing a given function at some point in the cardiac cycle whereby the QRS of the EKG triggers a second machine. X-rays may be taken at a certain point in the cardiac cycle, or with cineangiography of the coronary vessels, the dye may be injected at the desired point in the cardiac cycle. Lown has recently devised a "cardioverter" synchronized to the cardiac cycle which will apply direct current shock briefly in one phase of the cardiac cycle, thereby minimizing the likelihood of causing ventricular fibrillation. Harkins has devised a "cardiac resuscitator and assistor" which is synchronized to the patient's electrocardiogram to apply external cardiac massage at the moment of systole, thereby aiding the contracting force of the heart and increasing its output during acute failure.

This is an interesting group of instruments; some represent real advancements in diagnosis or treatment or in investigative technique; others are simply gadgets and will soon be discarded.

Grant Wilmer, M.D.

M.D.s "Key" to 2nd Kerr-Mills Expansion

EFFECTIVE SEPTEMBER 1, 1962, the Georgia Kerr-Mills program of health care benefits for Old Age Assistance recipients will be expanded for the second time since its inception eight months ago. Elsewhere in this issue of the *Journal*, you will find the new rules and regulations governing the broadening of benefits for Georgia's needy senior citizens.

As the doctor is the "key man" in determining medical need for hospital or nursing home admissions, it behooves the physician to study these new regulations and to cooperate in the tradition of medicine to see that the program is carried out as it was intended to operate.

MAG Undertakes Responsibility

Your Medical Association of Georgia has undertaken the responsibility of certifying that the patient's illness or injury comes within the scope of this program for hospital admission and that the length of hospital stay is commensurate with the diagnosis. While each individual physician will, of course, continue to determine medical need under the new rules of the program, MAG solicits the cooperation and support of doctors in the following areas:

(1) It is imperative that physicians give full medical data on each patient's condition on the claim form so that these claims may be certified without having to return the form for additional data or to reject the claim because the incomplete medical diagnosis leaves some doubt as to whether the illness or injury comes under the program;

(2) Physicians should also realize that hospitalization benefits are available only to those patients whose illness or injury normally requires such hospitalization for treatment;

(3) Another important regulation stipulates that while the annual total number of hospital days for any one calendar year has been expanded to 60 days, any one hospital admission is limited to 15 days unless the doctor files a special report for MAG

approval for from one to 15 additional days of hospitalization—and this special report form must be filed by the attending physician on or before the fifteenth day of the original hospital admission.

(4) The physician must bear in mind that patients are not eligible for hospitalization under this program for: cancerous conditions, tuberculosis, psychoses, or other conditions covered by another program. Recipients are not eligible for hospitalization for any minor surgery or treatment that can be performed outside the hospital. And admissions for diagnostic studies do not come within the scope of the program.

Added Expansion

It is also important to note that with this expansion of the Kerr-Mills health care of the aged program, the State Welfare Department is expanding the "Aid to the Blind" and the "Aid to the Totally and Permanently Disabled" programs to match these new Kerr-Mills benefits. Your Medical Association will also certify these claims in like manner as under Kerr-Mills.

Profession's Answer

We well know that Kerr-Mills is the profession's answer to the medical care problems of the needy aged. Our Georgia program has been successful in meeting this need in the areas covered—and its continued success depends upon the endorsement, support, and cooperation of the physicians of Georgia. We must prevent abuses and unnecessary over-utilization in determining medical need for the broad benefits available to eligible recipients as we endeavor to provide health care for the aged. Based on the past eight months' experience with the Georgia Kerr-Mills program, we have little doubt that the medical profession will meet these responsibilities.

John T. Mauldin, M.D., Medical Director
Adult Medical Programs

Georgia's Expanded Medical Assistance to the Aged Program Effective September 1, 1962

August 24, 1962

TO: DOCTORS OF MEDICINE PRACTICING
IN GEORGIA

RE: (1)—SECOND EXPANSION OF BENEFITS OF MEDICAL ASSISTANCE TO THE AGED ACT (Kerr-Mills Program)

AGAIN WE ARE PLEASED to report a major expansion in Georgia's Medical Assistance to the Aged program (Kerr-Mills Law), effective for eligible patients admitted to the hospital on or after September 1, 1962. This expansion provides for an increased length of hospital stay per admission, if requested; an increased annual total number of days of hospitalization; and a broadening of regulations governing medical eligibility for hospital admissions. The doctors of Georgia are to be commended for their cooperation with this program which has been the key to its success.

Specifically, these new expanded benefits for Old Age Assistance recipients under our Kerr-Mills program, as jointly approved by the Medical Association of Georgia and the State Department of Welfare are:

(1) If requested by a "special report" by the attending physician on or before the fifteenth (15th) day of hospitalization, an extension from one (1) to fifteen (15) additional days will be granted by the Medical Association of Georgia *when justified*.

(2) Extension from thirty (30) days to sixty (60) days of hospitalization total in any one calendar year; and

(3) Broadening of medical criteria for hospitalization from acute or emergency conditions, cataract extractions, and prostate gland resections to hospitalization for any illness or injury normally requiring such hospitalization for treatment, with the exception of cancerous conditions, tuberculosis and psychoses.

No recipients are eligible for hospitaliza-

tion for minor surgery or treatment that can be performed outside the hospital. Admissions for diagnostic studies are not eligible. No person shall be eligible for hospitalization under this program to the extent that he is otherwise eligible for treatment under any other program.

Nursing Home care benefits under this program remain unchanged and physicians will continue to certify medical need for patient admission to skilled nursing homes as in the past.

Full regulations for the program are enclosed for your study. The Medical Association of Georgia, by contract with the Welfare Department, will continue receiving hospital claims for medical review.

RE: (2)—TWO OTHER WELFARE DEPARTMENT PROGRAMS EXPANDED TO MATCH KERR-MILLS HEALTH CARE BENEFITS

The Welfare Department also wishes to inform the physicians of Georgia that with the approval of the Medical Association of Georgia, the "Aid To The Blind" and the "Aid To The Totally And Permanently Disabled" programs of hospital and nursing home benefits will be exactly the same as the benefits to Old Age Assistance recipients under Kerr-Mills as noted above. The Medical Association will provide medical review for these additional programs. The regulations for these two other programs are also enclosed. These three programs are to be known in the future as the "Adult Medical Programs."

May we take this opportunity to express our appreciation to all the physicians of the state for outstanding service in behalf of those needy patients who are receiving assistance under the Kerr-Mills health care of the aged program.

Cordially yours,

John T. Mauldiu, M.D.,
Secretary Medical Association of Georgia
Medical Director,
Adult Medical Programs
Alan Keuper, Director
State Department of Welfare

MEDICAL ASSISTANCE TO AGED / Continued

Rules and Regulations Governing the Hospital Care Program for Adult Assistance Programs' Recipients for the State of Georgia As Amended Effective September 1, 1962

SECTION I

Method for Approval of Participating Hospital

Section 1.1 Procedure for Becoming a Participating Hospital

1. Prerequisite to any hospital becoming a participating hospital under the Hospital Care Program, the governing authority of the hospital must elect to participate in the Program.
2. In expressing the desire of the hospital to participate in the Program, a responsible officer of the hospital shall complete a standard application form and shall submit such application to the Georgia Department of Public Welfare.
3. A hospital once approved will continue as a participating hospital until it voluntarily withdraws or its approval is revoked.

Section 1.2 Requirements for Becoming a Participating Hospital

1. To be eligible to participate in the Program, a hospital must have been issued a current license permit under the laws of this state and must not be operated primarily for the care and treatment of tuberculosis, mental disorders, or other long term care of chronic diseases or illnesses. Rules and regulations for participation by out-of-state hospitals are provided in Section V.
2. To be eligible to participate in the Program, a hospital must be a general hospital providing major medical surgical services and/or acute short-term care.
3. To be eligible to participate in the Program, a hospital must maintain within the faculty such standards as are hereinafter set forth:
 - (a) Have an organized governing body with rules and regulations;
 - (b) Continuous registered nursing service—nursing service under the supervision of registered graduate nurses, 24 hours a day, 7 days a week;
 - (c) Adequate medical records;
 - (d) Readily available diagnostic X-ray facilities;
 - (e) Laboratory facilities;
 - (f) Adequate diet kitchen;
 - (g) A medical staff with rules and regulations;
 - (h) At least six (6) beds for the care of non-related illnesses, the average stay of which is in excess of twenty-four (24) hours per admission;
 - (i) And be able to furnish cost data required in the filing of Georgia Hospital Cost Statement, or agree to accept a minimum all-inclusive per diem established by the Georgia Department of Public Welfare.
4. Any hospital accredited by the Joint Commission on Accreditation of Hospitals or The Georgia Hospital Medical Council will qualify as meeting minimum standards hereinbefore set forth under (a) through (i).
5. Any hospital not accredited by the above mentioned accreditation agencies shall complete a standard questionnaire form and shall submit such form to the Georgia Department of Public Welfare for use as a basis in determining eligibility for participation.
6. Any hospital electing to participate in the Program must agree to accept a calculated per diem related to the non-profit basic cost and must agree to submit a standard cost statement form to substantiate a "non-profit basic cost."
7. In the absence of a standard cost statement, any hospital electing to participate in the Program must agree to accept

an all-inclusive rate of ten dollars (\$10.00) per patient-day of care. An accepted standard cost statement shall be considered as out-dated six months after the end of a hospital fiscal year, and if a new cost statement is not submitted within a reasonable length of time, generally considered to be six months, the all-inclusive per diem rate will revert to \$10.00.

Section 1.3 Certification as a Participating Hospital

1. Hospitals found eligible for participation in the Program shall be so certified by the Georgia Department of Public Welfare and the Department shall maintain a roster of hospitals participating in the Program and shall furnish a list of such hospitals to each County Welfare Department with changes as needed. Each participating hospital will be assigned a permanent code number which must be used on all claims.

Section 1.4 Discontinuance as a Participating Hospital

1. A participating hospital has the right to withdraw from the Program at any time, after written notice at least thirty (30) days in advance of this intent to the Georgia Department of Public Welfare, provided that the rights of patients are not jeopardized.
2. Should a participating hospital, at some future date, fail to comply with Rules and Regulations of the Program, the Georgia Department of Public Welfare shall remove the hospital from the roster of participating hospitals and shall advise the hospital concerned and the County Welfare Department that the hospital is no longer a participating hospital under the Program. The hospital will be given written notice at least thirty days prior to removal from roster.

Section 1.5 Calculating the Per Diem Rate

1. The non-profit basic cost shall be determined from an analysis of the hospital's financial records and reports and all submitted cost statements must bear the certification of a registered public accountant who is not an employee of the hospital.
2. The Georgia Department of Public Welfare shall establish for each participating hospital an official per diem rate, which shall be an established percentage of the non-profit basic cost, or one hundred per cent (100%) of the non-profit basic cost subject to a maximum, as determined by funds available. A tentative per diem rate will be negotiated in the case of a new hospital which does not have sufficient operating periods to establish a sound basic cost rate.
3. "Standard cost statement" hereinbefore referred to means Georgia Hospital Cost Statement with related rules and regulations now used for other medical care programs under the sponsorship of the State of Georgia. The Georgia Department of Public Welfare shall not require the submission of additional cost statements for this Program.
4. A participating hospital grants to the Georgia Department of Public Welfare, the Federal Department of Health, Education, and Welfare, and the Comptroller General of the United States the right to audit submitted cost statements and claim records against its financial records, and the right to inform county welfare departments of its per diem rate.
5. For any participating hospital, the official per diem rate shall not exceed the average computed cost per in-patient day based on private billing charges as reflected on Georgia Hospital Cost Statement.

Section 1.6 Hospital Services Included in the Per Diem Rate

1. The official per diem rate shall be an all-inclusive charge to cover all in-patient hospital care provided patients under the Program, ordinarily in rooms of three or more beds, but when medically indicated or when no other accommodations are available, in rooms with a lesser number of beds, including the use of operating rooms, all treatment, therapeutic and diagnostic services, drugs and medicines, casts and dressings, oxygen, plasma, and all other services rendered by individuals who receive remuneration (salary or contractual basis) from the hospital for such services. There is no provision under the Program for paying of professional charges on a personal billing fee basis.

2. If an eligible recipient or his family should insist on the patient being placed in a private room when other accommodations are available or when it is not medically indicated, then the hospital may refuse to accept the patient as a welfare case and require the family or other resources to pay the entire account.

SECTION II

METHOD FOR DETERMINING PATIENTS ELIGIBILITY

Section 2.1 Persons Eligible for Hospital Care

1. Persons eligible for hospital care under the Program are recipients of Old Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled. These three programs hereinafter will be referred to as the Adult Program.
2. An authorized Adult Program recipient is eligible for a vendor payment for hospital care only in the months in which he is eligible for a money payment in one of the Adult Programs.
3. This definition of persons eligible for hospital care does not include the spouse not eligible in his or her own right although included in the Adult Program recipient's budget as an essential person.

Section 2.2 Eligibility in Relation to Number of Days Care

1. Each Adult Program recipient is eligible for a maximum of fifteen (15) days of hospital care per admission which may be extended up to an additional fifteen (15) days per admission on prior approval by the Medical Association of Georgia. Each recipient's entitlement is limited to a total of sixty (60) days of hospital care per calendar year.
2. Days of hospital care not used by an Adult Program recipient in one calendar year shall not be carried over to the next year.

Section 2.3 Certification of Eligibility for Hospital Care

1. The Director of the County Welfare Department of the patient's county of residence shall, if appropriate, certify that the patient is a recipient of assistance under one of the three Adult Programs and has entitlement to thirty (30) days of hospital care, or the number of remaining days of hospital care for which the recipient is eligible in the current calendar year, or the number of days until the patient's assistance payment is to be terminated or suspended, whichever is the smallest; or explain why hospitalization must be denied.
2. The hospital must request certification of eligibility on a standard Admission Notice form consisting of two (2) copies of a five (5) part snapshot Statement of Hospital Services form. The Admission Notice copies of the form carry patient identifying information and signature only.
3. When the certification of entitlement by the County Welfare Department exceeds fifteen (15) days, and the recipient's attending physician certifies that additional hospitalization is essential to the treatment of the patient, the hospital to qualify for an extended period of coverage must submit, prior to the expiration of the initial fifteen (15) days, a request for extension to the Medical Association of Georgia which may authorize additional hospitalization not to exceed fifteen (15) days per admission. A standard form (Form DPW 399) is provided for this purpose. (See Section 3.3 for details concerning the use of this form.)

SECTION III

CRITERIA FOR HOSPITALIZATION

Section 3.1 Definition of Reimbursable Hospital Care

1. This Program shall provide essential hospitalization for an acute illness or injury; elective surgery, and medical treatment as defined below in Section 3.1(2) for Adult Program recipients who have been certified as eligible for hospital care according to the eligibility criteria set forth in Section II of these Rules and Regulations.
2. The "acutely ill or injured" are defined as those otherwise eligible Adult Program recipients with acute illnesses or major injuries which cannot be treated adequately outside a hospital. Acute illnesses or acute medical conditions shall include acute exacerbations or acute complications of chronic diseases, surgical conditions requiring emergency

hospitalization, and acute emergencies of any nature which are a threat to the life and health of the patient. In addition to hospitalization for acute illness or injury, eligible recipients are entitled to hospitalization for necessary elective surgery and medical treatment which normally require hospitalization. No recipients are eligible for hospitalization for minor surgery or treatment that can be performed outside the hospital. Recipients are not eligible for hospitalization for diagnostic procedures. Admission must be for necessary treatment of illness or injury.

3. Hospitalization shall not be provided under this Program for a patient as a result of a diagnosis of tuberculosis, cancer or psychosis, except hospitalization for cancer involving an acute emergency or lifesaving surgical treatment to permit adequate time for transfer to the appropriate medical care State program, with such transfer at the earliest possible time.
4. No person shall be eligible for hospitalization under this Program to the extent that he is otherwise eligible for treatment under any other program including the State Cancer Program, Veterans Administration, Vocational Rehabilitation, Workmen's Compensation, or through the legal obligation of a contractor, public or private, to pay or provide for his care.

Section 3.2 Other Conditions Relating to Hospital Care

1. It shall be the sole responsibility of the Adult Program recipient's physician in consultation with the recipient to determine the participating hospital to which the recipient is to be admitted.
2. The hospital shall agree to complete necessary treatment and discharge the patient in the minimum number of days consistent with good medical care.
3. The recipient's attending physician must sign statement on the standard billing form that in his professional opinion the patient suffered the specified illness or injury at the time of admission to the hospital and that hospitalization was essential to the treatment of the patient.
4. The hospital from information furnished by the referring and/or attending physician must complete Section B—Medical Information on the standard billing form. Required information relates to admitting diagnosis; type of medical, surgical, or diagnostic procedure(s) rendered; and final primary diagnosis and secondary diagnosis, if any.

Section 3.3 Prior Approval of Hospitalization in Excess of 15 Days

1. When the hospital has received certification from a County Welfare Department that a patient is entitled to more than fifteen days' hospitalization per admission and in the physician's opinion more than fifteen days will be required to complete treatment, then the hospital's administrative officer and the physician should complete Form DPW 399, Request for Authorization for Hospitalization in Excess of 15 Days, not later than the fifteenth day of admission and submit it immediately to the Medical Association of Georgia. Extension may be granted up to a maximum of fifteen (15) days or the number of days' entitlement in excess of fifteen (15), whichever is lesser. Request for extension should be only for the actual number of days anticipated to be necessary. When request for an extension of less than 15 days is submitted and it later develops that more days are necessary, then additional requests may be submitted as long as the total number of days' extension requested do not exceed 15, or the number of days' entitlement in excess of fifteen (15), whichever is the lesser. Under no circumstances will the Department of Public Welfare be responsible for more than thirty (30) days per admission. The payment of any extension authorized is contingent upon the initial illness coming within the scope of the Program.

Section 3.4 Post Review of Medical Information

1. After discharge of the patient, the hospital shall submit claim for services through the Medical Association of Georgia for a post review of required medical information and determination that the illness or injury comes within the limitations of services for Adult Program recipients and the vendor service contained in the claim is reasonable as related to the diagnosis. Payment of a claim for services is contingent upon approval by the Medical Association of Georgia for conformity with the medical aspects of the rules and regulations.

MEDICAL ASSISTANCE TO AGED / Continued

SECTION IV

HOSPITAL CLAIM FOR SERVICES

Section 4.1 Claim Form

1. The hospital's claim for services must be submitted on a properly completed Statement of Hospital Services, Form DPW 397, provided for this purpose.

Section 4.2 Calculating Amount Due Hospital

1. The hospital must submit only one claim for services per admission, the claim to cover the entire period of service from date of admission to date of discharge. The claim for services must show the calendar date of admission, the calendar day of discharge and total days in hospital.
2. The following accepted hospital practices in counting a patient day shall be followed in determining the count of total days in hospital. A day shall begin and end at midnight, the customary census-taking hour for hospitals. A day shall include the day of admission, but not the day of discharge, except when a patient is admitted and discharged on the same day. The day of discharge shall not be counted as a patient day even though the patient leaves after a particular hour referred to as a "check-out" time. When a patient expires in the hospital, the calendar day of death shall constitute the date of discharge.
3. As stated above in Section 4.2(1), a claim for services must cover the entire period of services from date of admission to date of discharge. The word "discharge" is defined as meaning a physical discharge as evidenced by the patient actually leaving the hospital. In those rare instances where patient leaves the hospital but becomes acutely ill later in the day and has to be readmitted on the same day of discharge, the hospital shall attach a letter to the claim explaining the circumstances and certifying that the patient physically left the hospital and had to be readmitted on the same date.
4. The hospital in determining the number of days for which the State assumes responsibility shall compare the following: (1) The number of days certified by the County Welfare Department as the patient's maximum entitlement; (2) The total number of additional days of hospitalization (if any) approved on Form(s) DPW 399 plus fifteen (15) days; and, (3) The total days in the hospital. Then, use the smallest of the three figures times the official per diem rate in computing the total amount due hospital.
5. When a hospital's official per diem rate is changed, for any reason, the rate in effect on the date the patient is admitted to the hospital shall be used in computing the total amount due the hospital.

Section 4.3 Payment from Other Sources

1. Payment by the State to the hospital at the official per diem rate shall be considered full payment for all services rendered during the period of hospitalization for which the State assumes responsibility and the hospital shall accept no payment *in excess of the agreed rate* from the patient or other person for said period. Hospitalization insurance and other third party payments shall be considered as payment in part of the agreed rate and treated in accordance with Section 4.3(2) below.
2. The hospital shall apply as a credit in determining the net claim for payment due from the State any hospitalization insurance or other third party payment *applicable to the period for which the State assumes responsibility*, said period to be construed as beginning on the date of admission. (See Section 4.4(4) for determining when "applicable to the period for which the State assumes responsibility.")
3. Should the hospital collect from the patient or his family any amount for services rendered during the period of hospitalization for which the State assumes responsibility, even though such payment may be for services and/or accommodations of a class better than that provided by the State, as defined in Section 1.6(1), the payment shall be applied as a deduction from the agreed rate in the same manner as provided for hospitalization insurance and other third party payments in Section 4.3(2) above.
4. The hospital shall be free to seek payment from ap-

propriate sources for any days of hospital care required by the patient beyond the period of hospitalization for which the State assumes responsibility, except no payment shall be sought from personal funds of an Adult Program recipient. The exclusion of personal funds of an Adult Program recipient shall not apply to hospitalization insurance or other third party payment paid directly to the patient instead of the hospital.

Section 4.4 Deductions from Claim—Insurance, etc.

1. The hospital shall determine the amount of hospitalization insurance benefits available to the recipient and shall take into account such insurance and all other payments made to the hospital (when applicable to the period authorized for payment) in determining the net claim or payment due from the State, as stated in Section 4.3 (2) and (3). The claim for services form has a line for the deduction of such collections from total amount due the hospital, on a due or received basis.
2. If a hospital receives unreported insurance or other third party funds for the period authorized for payment after the bill is paid, it shall be the responsibility of the hospital to reimburse the State Department of Public Welfare.
3. In the rare instances when insurance or other third party funds applicable to the period authorized for payment exceeds the per diem rate, the hospital may elect not to complete and file a statement of hospital services. In such instances, the hospital must agree to accept such funds as payment in full for services rendered during the period for which the State assumes responsibility; and must return the approved admission notice to the certifying County Welfare Department with a letter of particulars, in order that days encumbered against the recipient's days of entitlement because of the certification may be canceled.
4. The hospital shall determine what portion of insurance and other third party funds are applicable to the period authorized for State payment in accordance with the following general rule. In insurance benefits, the stipulated daily amount for bed and board shall be applied at said rate beginning with the day of admission until exhausted, an allowance for extras shall be applied against appropriate charges beginning with the day of admission until exhausted. However, in cases of surgery, allowance for extras may be applied beginning with the day of surgery instead of day of admission. Where payment represents a lump sum hospitalization or injury settlement from an insurance company or other third party, without stipulation as to days of coverage, etc., the total payment shall be divided by the total days in hospital to arrive at a daily rate, then, multiply the rate thus obtained by the number of days in the period authorized for State payment to arrive at deductible amount to be shown on claim form.

Section 4.5 Submission of Claim Form

1. Completed claim form must be signed by an administrative officer of the hospital and submitted, in duplicate, to the Medical Association of Georgia for post review of medical information. (See Section 3.4(1).)
2. Claim form will not be accepted unless accompanied by
 - (a) Copy of Admission Notice certified by the Director of the County Welfare Department of the patient's county of residency as to eligibility for hospital care and days of entitlement.
 - (b) A copy of the patient's itemized statement, carrying customary detail, by days, of accommodations and services with private patient charge rates; also, reflect credit entries of collections from all sources applicable to the particular account. This statement of account must cover the total days of hospital care.
 - (c) Copy of Form DPW 399, Request for Authorization for Hospitalization in Excess of 15 Days, approved by the Medical Association of Georgia if the number of days for which claim is submitted exceeds 15 days.
3. In order to keep a close check and accurate statistics on the cost of hospital care, hospitals are asked to submit claims for payment within ten (10) calendar days after the discharge of each patient, except in situations involving inability to determine the exact amount of a third party credit. A delay is preferable in such cases but shall not exceed ninety (90) days after the date of discharge.
4. Any claim which is unpaid six months after the month

of discharge cannot be paid under Federal fund restrictions on delayed vendor payments.

5. The State Department of Public Welfare shall pay all approved claims directly to participating hospitals.

SECTION V

OUT-OF-STATE HOSPITALIZATION

(This section deals with out-of-state hospitalization with which Georgia physicians are not concerned and is not printed herein.)

SECTION VI

MEDICAL DECISIONS AND APPEALS

Section 6.1 Source of Regulations on Medical Decisions and Appeals

1. Procedural regulations concerning contacts with physicians and hospitals relating to medical decisions and the right of appeal granted an Adult Program recipient and vendors furnishing services under the Program are taken from Agreement on Hospital Care between the Georgia Department of Public Welfare and the Medical Association of Georgia.

Section 6.2 Medical Decisions

1. The State Department of Public Welfare shall utilize the services of the Medical Association of Georgia in making contacts with the hospitals and physicians relating to medical decisions and the Medical Association of Georgia shall make such contacts except where the exigencies of efficient and proper administration require direct contact by the State Department of Public Welfare. Where it is necessary

for the State Department of Public Welfare to make direct contacts with hospitals and physicians relating to medical decisions, the State Department of Public Welfare shall endeavor to advise the Medical Association of Georgia in advance of any such direct contact. The Medical Association of Georgia shall keep the State Department of Public Welfare informed of problems encountered in discharging its duties under this program and will advise as to the need for policy changes.

Section 6.3 Appeal by a Recipient

1. In the administration of the hospital care program for Adult Program recipients, any recipient who believes that he has not been given proper consideration shall have the opportunity for a fair hearing before the Director of the State Department of Public Welfare. The Medical Association of Georgia shall cooperate with the State Department of Public Welfare in obtaining the true facts from hospitals, physicians and related personnel in all cases where a recipient has requested a fair hearing in connection with the hospital care program. The decision of the State Department of Public Welfare on the issues in question shall be binding.

Section 6.4 Appeal by a Hospital

1. In the administration of the medical aspects of the hospital care program for Adult Program recipients, any vendor who feels that he has not been given fair and equitable treatment shall have the right to appeal to the Medical Association of Georgia. In the event the decision which he is appealing is sustained, he shall have the further right of appeal to the Director of the State Department of Public Welfare. The Director of the State Department of Public Welfare may, of his own motion, review, de novo, any appeal of an aggrieved vendor.

VANDIVER ANNOUNCES OPENING

OF NEW GRACEWOOD INFIRMARY

Governor Ernest Vandiver announced July 14, 1962, that the state will begin moving patients into the new 300-bed Infirmary Building at Gracewood State School and Hospital in October.

The building, which Governor Vandiver said will be put into operation with a special allocation of \$300,000 he has provided, will relieve desperately over-crowded conditions at Gracewood.

"This structure is part of a 16 million dollar mental health building program for Gracewood and Milledgeville State Hospital for which I broke ground last year," the Governor declared.

The new infirmary building is designed to give total care for 300 Gracewood residents with chronic neurological diseases of childhood. It contains ten independent units, each providing beds for 30 residents.

Each unit contains a sleeping area, bath, playroom, occupational therapy room, nurse's station, nurse's lounge, visiting area and isolation room, Governor Vandiver explained.

The individual units will function as specialized wards for certain severe disabilities and will be independent of other areas except for food service.

The new building was completed July 1, and is expected to be accepted soon by the State Hospital Authority. Installation of equipment began in August.

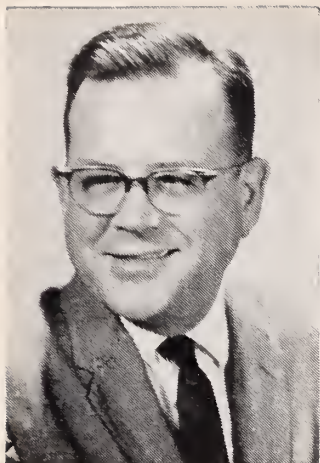
Staff for the hospital is now being secured. Dr. Norman B. Pursley, Superintendent of Gracewood, said a team comprised of pediatricians, dentists, nurses, physiotherapists, occupational therapists and other allied personnel will work as a close-knit unit to provide individual care for each severely handicapped child or adult housed in the building.

It is anticipated that six full wards of the ten-ward infirmary will be opened by January 1, 1963, and the remaining wards will be opened as the needed personnel are secured.

Current patient population of Gracewood is 1,600, with a waiting list of about 1,000.

Two new 50-bed dormitories have already been opened for Negroes to house patients with multiple physical disabilities.

Administration of the school, located near Augusta, was transferred to the State Department of Public Welfare on July 1, 1960, under a legislative act sponsored by the Vandiver administration.



IT'S SO REGULAR

WHEN I WAS A BOY, I used to spend every summer with my family down on the coast. My brothers and I had an old bateau which we used for fishing. This was in the days before outboard motors and we used to have to row out to the fishing grounds. One of our companions was an old one-legged Negro and he used to say to us, "Dis rowin' ain't so bad 'ceptin' it's so regular and when yo' is rowin' ag'in de tide you can't git no rest."

For years now the doctors of America have been rowing against the tide, against the rising tide of socialism in this country of ours. It manifests itself in every walk of life and every phase of our economy. It has resulted in a "get something for nothing" philosophy which is undermining the moral fibre of our people. One pertinent manifestation of it has been the drive in recent years to socialize the practice of medicine which culminated in the introduction of the King-Anderson Bill into Congress.

As a result of an heroic effort on the part of organized medicine and by individual efforts of thousands of doctors, we have been able to stall this type of legislation for another year. We have not done this alone but with the help of our many friends who, at heart, are conservatives just as we are and who deplore some of the things that are happening in Washington. The President of the United States has already said that this issue will be the deciding one in the congressional elections this fall and that the passage of the King-Anderson Bill will have top priority in Congress next year.

It behooves us as physicians, both individually and collectively, to continue to make our influence felt during the coming months and to do everything we can to see to it that a conservative Congress is elected. We must continue to row against the tide. To show people by precept and example that we are worthy of the trust so far placed in us. We must be firm in our conviction that further implementation and strengthening of the Kerr-Mills Law, plus adequate and widespread voluntary prepaid insurance, can do the job adequately. We must again convince our friends, inside and outside of Congress, that private enterprise in this important segment of our economy is worth saving. The tide is still running. We cannot lose but once. We cannot yet rest on our oars.

J. W. Gooden
President, Medical Association of Georgia



PSYCHOANALYSIS AND THE FAMILY NEUROSIS

Martin Grotjahn, M.D., *Beverly Hills, California*

IT IS DIFFICULT, perhaps impossible, to express my ideas about psychoanalytic therapy of the family in limited space. After all, I needed for this purpose not less than 350 pages in my book, *Psychoanalysis and the Family Neurosis*, (W. W. Norton, New York, 1960).

In the 30 years of my work as a physician, psychiatrist, and psychoanalyst, I always was searching for better therapeutic results of psychoanalysis and for greater economy of treatment. In my search to deepen my insight into my patients and to find more effective ways to help them, I remembered Freud's statement, that a patient is like a boat tied to a pier; it can move and sail the seven seas freely only when all the ropes with which it is tied to the pier are cut. I believe that every individual neurosis is anchored — more or less firmly — in the correspondent or complementary neurosis of another person. Frequently, the analysis or psychotherapy of one person remains incomplete, because the patient's wife or husband, daughter or son, brother or sister, father or mother, may have an unconscious hold on the patient through this complementary neurosis. A masochistic woman may analyze her masochistic attitude towards her husband in analysis only to see that her sadistic husband expects her to adjust to him in a way which asks for her character perversion.

Therapy May Be Limited

A neurotic mother may feed unconsciously the neurosis of her son or her daughter; or a father in conflict about some criminal unconscious trends in himself may seduce his children to do what he

does not dare but wishes to do. The analysis of a child is perhaps the best example that therapy with the child alone is limited. The mother or the father has to be included into the treatment, otherwise, we would expect the child to become the therapist of his parents. In favorite circumstances this may happen; as a rule it does not work too well.

Analytic family treatment is different from supportive or environmental, situational or counseling services. Analytic family therapy consists in understanding the unconscious of the primary patient and the unconscious of his spouse. It also aims at the understanding of the unconscious relationship and interaction between the patient and his human environment.

Importance of Family Therapy

We see the importance of such family therapy clearly in the therapy of children, but also in the therapy of schizophrenics. The Atlanta Psychiatric Clinic under the directorship of Carl Whitaker and Thomas Malone has done important pioneering work in this respect. The open-minded, clinical, analytically trained observer will see that almost every psychiatric disturbance is partly intra-personal and to another part inter-personal. The psychoanalytic therapy which I have in mind puts equal emphasis on both aspects of the neurotic unconscious conflict.

BIBLIOGRAPHICAL NOTE

For details of analytic family treatment see Martin Grotjahn: *Psychoanalysis and the Family Neurosis* (W. W. Norton, New York, 1960).

For an introduction to psychodynamic reasoning see Martin Grotjahn: "Beyond Laughter", *A Psychoanalytic Study of Humor*. (McGraw-Hill, New York, 1957).

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.



THERAPEUTIC ABORTION

John L. Moore, Jr., *Atlanta*

THE RECENT SAD DISCLOSURES about the effect of the drug thalidomide when taken by women in the early stages of pregnancy, make it appropriate to discuss on this page the Georgia law relating to abortion. It will be recalled that recently the Arizona courts refused a petition for abortion by a woman who had taken thalidomide during the early stages of pregnancy.

The subject is dealt with in the Georgia laws in the portion relating to criminal law. It is declared to be a misdemeanor for any person to administer wilfully to a pregnant woman any medicine, drug, or substance, or to employ any instrument with intent to produce the miscarriage or abortion of the woman "unless the same shall be necessary to preserve the life of such woman, or shall be advised by two physicians to be necessary for that purpose . . ."

This section has been construed to apply only to causing abortion at a time when the child is not legally "quick." The Georgia cases on this subject define a "quick" child to be an unborn child so far developed as to be alive when the abortion was caused.

Georgia Law Defined

Unless the abortion is necessary to preserve the life of the mother or shall be advised by two physicians to be necessary for that purpose, causing the abortion of a "quick" child is defined by Georgia law to be "an assault with intent to murder." An assault with intent to murder is punished by imprisonment and labor in the penitentiary for not less than two years nor more than ten years. A misdemeanor is punished by a fine of \$1,000 or imprisonment up to one year or both.

It will be immediately noticed that the crime of abortion or use of medicine with intent to murder an unborn child is committed unless the abortion is necessary to preserve the life of the woman. Nothing is mentioned about any necessity to prevent the birth of a malformed child. Consequently, it would appear that if it is unnecessary to save the life of the mother, the crime would be committed if abortion were caused for the purpose of preventing the birth of a malformed child because the mother had taken the drug thalidomide.

A Massachusetts Decision

One Massachusetts decision has said that abortion might be lawful to preserve the life of the mother in the sense that two medical doctors agreed there was a substantial likelihood that the mother, if she carried the child to full term, would commit suicide. If the Massachusetts case were considered good law in Georgia, and it probably would be, then abortion might be justified if the mother had taken the drug thalidomide and exhibited such signs of mental illness that two physicians considered it necessary to save her life because she might commit suicide.

Undoubtedly, an application to the courts in Georgia would be of no use. The order of a judge is unnecessary in the case of a therapeutic abortion to save the life of the mother. The judge would be powerless to add to the present laws of Georgia as on the statute books if the purpose of the abortion were to prevent the birth of a malformed child.

Newspaper comments in Georgia with reference to the Arizona application mentioned earlier favored a change of the statutory law in this state to allow

abortion upon proof that the mother had taken thalidomide in the early stages of pregnancy considered most dangerous. It is hard to see how such a statute could be satisfactorily worded. Possibly, it could be

phrased in terms of a requirement that a certain number of medical doctors concur in their judgment that the likelihood of a malformation in the child is extremely high.

Prepared at the request of the Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller and Gaines, general counsel for the M.A.G.

**AMERICAN COLLEGE OF PHYSICIANS
PRESENTS POSTGRADUATE COURSES**

Two postgraduate courses dealing with the major complexities and advances in internal medicine will be presented October 1-5 by The American College of Physicians in Portland, Oregon, and Richmond, Virginia.

Course No. 1, of a series of 15 to be offered during 1962-63, will be held at the University of Oregon Medical School, Portland, Oregon. Titled "Difficult Contemporary Problems in Internal Medicine," it will be co-directed by Howard P. Lewis, M.D., F.A.C.P., Professor and Head, Department of Medicine, University of Oregon Medical School, and Daniel H. Labby, M.D., F.A.C.P., Professor and Head, Department of Metabolism, Nutrition and Diabetes, University of Oregon Medical School. Under their supervision, 38 specialists in internal medicine will lecture on various phases of the specialty, including the cardiovascular system, gastroenterology, and genetics.

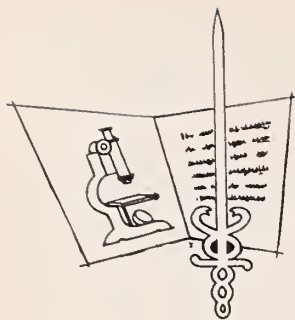
Special guest lecturer will be Wesley W. Spink, M.D., F.A.C.P., Minneapolis, Minnesota, Professor of Medicine of the University of Minnesota Medical School and President-Elect of The American College of Physicians, who will speak on infectious diseases.

The second course of the series titled "Basic Mechanisms in Internal Medicine," to be presented at the Medical College of Virginia, Richmond, Virginia, will deal with new and significant advances in internal medicine, with emphasis on the pathophys-

iologic concept as related to clinical manifestations and the therapy of disease. It will be directed by W. T. Thompson, Jr., M.D., F.A.C.P., Richmond, Virginia, Professor and Chairman, Department of Medicine, Medical College of Virginia, and co-directed by Charles M. Caravati, M.D., F.A.C.P., Richmond, Virginia, Professor of Clinical Medicine, Medical College of Virginia, and Kinloch Nelson, M.D., F.A.C.P., Richmond, Virginia, Professor of Medicine and Director of Continuing Education, Medical College of Virginia.

The A.C.P.'s postgraduate program, now in its twenty-fourth year, was first conceived in 1938 by the Board of Regents, according to Edward C. Rosenow, Jr., M.D., Philadelphia, Pennsylvania, Executive Director. At that time established physicians had to depend primarily on general meetings and personal research to keep abreast of intricate new advances in their fields.

Dr. Rosenow pointed out that as doctors responded to the idea of intensive depth study of various aspects of internal medicine, the courses were expanded, both in subject matter and the quantity offered. More than 200 have been presented since that time, with an estimated total enrollment of 20,000 specialists, covering such diverse areas of study as medical genetics, neurology, drug therapy, cancer, psychosomatic medicine, cardiology, endocrinology and the internist's role in pre- and post-operative problems.



THE CHANGING PICTURE OF CERVIX CANCER

William J. Pendergrast, M.D., and Calvin B. Stewart, M.D., *Atlanta*

A SURPRISING NUMBER of lay people and many of our medical personnel still approach all cancer with a feeling of fear and hopelessness. It seems apropos to point out the amazing change which has taken place in the overall picture of cervix cancer and to emphasize the possibility of eliminating this disease as a major cause of death.

The results reported by the International Federation of Gynecology and Obstetrics emphasize this change. The reports from the Roswell Park Memorial Cancer Hospital are typical and graphically illustrate this change. Stage I cancer of the cervix accounted for only about five per cent of the cases in 1920 and had a five year cure rate of 60 per cent. The percentage of early cases has increased steadily since 1935. The diagrams below indicate that by 1954 about forty per cent of the cases were Stage I and the cure rate had increased to about 75 per cent. In 1920 almost half the cases were Stage IV.

Diagram 1.

Proportion of cases allotted to the different stages

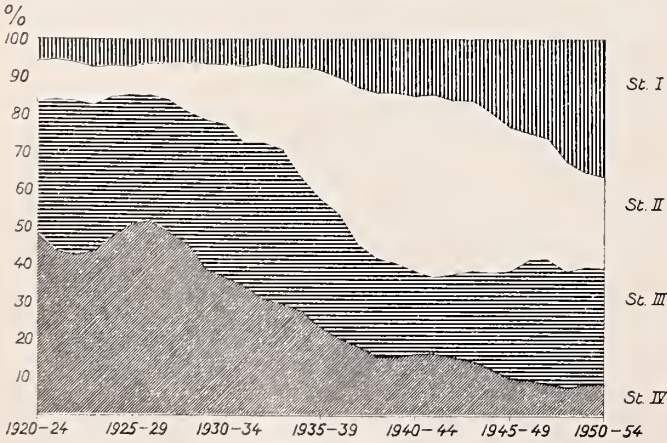
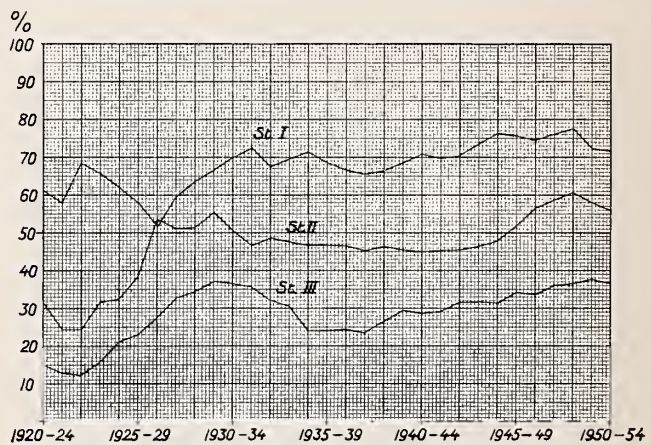


Diagram 2.

5-year apparent recovery rate in the different stages.



By 1954 less than ten per cent were in this stage.

This trend has continued in recent years. In our private practice over half the cases are Stage I, and the five year cure rate has increased to almost 80 per cent. A most encouraging observation is that more and more of the cases are being picked up in the pre-invasive stage and are being managed by the local physician. We anticipate with pleasure the day when the advanced case will be a rarity, and the cure rate will approach 100 per cent.

The papanicolaou smear has given us a tool to accomplish this goal. We must remember, however, that the smear is a screening device to be used in normal women and is not a diagnostic test. The patient with an abnormal cervix or smear should have an office biopsy from multiple sites.

We do not have the solution to the problem of cancer. With our present knowledge properly applied, we could eliminate cancer of the cervix as a major cause of death.

Approved by Professional Education Committee, Georgia Division, ASC.



HEART DISEASE IN PREGNANCY

F. Dempsey Guillebeau, M.D., *Albany*

THE PROPER MANAGEMENT of the pregnant woman requires recognition of organic heart disease when it is present. Findings during a normal pregnancy, however, may closely simulate heart disease with congestive heart failure. Dyspnea on exertion, edema of the legs, and palpitations are frequent symptoms during the latter half of pregnancy, at the same time when complications of heart disease, if present, usually appear. These symptoms in association with such signs as apical and pulmonary systolic murmurs, apical impulse displaced to the left by the elevated diaphragm, early diastolic third heart sound, and an increase in the transverse diameter of the heart on x-ray, all of which may be found during normal pregnancy, may lead to an erroneous diagnosis of heart disease. The mammary souffle due to increased blood flow to the breasts or even a normal venous hum may give auscultatory findings similar to patent ductus arteriosus. Despite these similarities, the diagnosis of heart disease is made when present in the great majority of cases by careful evaluation of the history, physical, and X-ray studies. In a few patients the significance of certain murmurs must be determined several weeks after delivery when the circulatory hemodynamics have returned to the non-pregnant level. Since 85 per cent of all heart disease during pregnancy is rheumatic in origin (the remainder primarily congenital), and the majority of these have some degree of mitral stenosis, the recognition of the typical diastolic murmur of this condition is necessary. An aortic diastolic or a mitral pansystolic murmur should also be considered evidence of valvular disease. Diastolic murmurs and distinct cardiac enlargement are, in general, the most reliable signs of heart disease during pregnancy.

Once the diagnosis of heart disease has been established, there are two questions which the physi-

cian must consider. (1) Should the pregnancy be continued or interrupted? (2) If the pregnancy is to be allowed to continue, what is the proper course of management? In answering the first of these the threat of the pregnancy to the life of the mother, the present size of her family, the desire for a baby, the ability of the mother to care for the child after birth, and the religious convictions of the family all bear weight. The presence of heart failure at the time of conception or its appearance during the first trimester is, in general, a bad prognostic sign, and it is here that the question of either interrupting the pregnancy or allowing its continuation is most difficult to answer. If the decision is for termination, it should be done before the 15th week, while it still may be carried out by the vaginal approach. After that time the sum of clinical experience would indicate that the risk of interruption, which would require hysterotomy, is greater than that of continuing the pregnancy. As medical management of the pregnant cardiac has become more refined, the interruption of pregnancy has become seldom necessary. Ninety-eight to ninety-nine per cent of pregnant cardiac patients can be expected to survive the pregnancy. Fetal mortality is directly proportional to the severity of the heart disease and ranges from a normal seven per cent in asymptomatic patients to approximately 50 per cent in class IV individuals.

The proper medical management of the pregnant patient with heart disease requires knowledge of the physiological changes that occur during pregnancy. Notable among these are, progressive increases in pulse rate, pulse pressure, cardiac output, and blood volume in the first seven or eight months of pregnancy. During the last one or two months, these changes reverse their direction so that by the time of delivery these functions are appreciably lower than

at their peak. From a practical standpoint of management, this means that the load on the heart increases to the seventh or eighth month, and then decreases so that a patient who does well through the period of peak load should have no difficulty with delivery. The presence of heart disease is not itself an indication for caesarean section.

The major problem in management is the prevention and control of heart failure. For best results the patient should be seen early in pregnancy and followed at one to two week intervals depending on her cardiac status. Sudden weight gain should be considered evidence of fluid retention, and salt restriction and diuretics ordered as indicated. Infection should be treated early, and anemia corrected if present. If heart failure appears, the usual measures of rest, digitalis, and diuretics are administered. In some very cooperative patients a decrease in serially deter-

mined vital capacity measurements may give an early clue to the appearance of failure since normally the vital capacity does not decrease during pregnancy. Rather rigid salt restriction is desirable after the fourth month when the increase in circulatory load begins to rise rather sharply. Patients with severe heart disease may require modified bed rest throughout pregnancy. During the peak load at the seventh month, it may be advisable to admit the patient to the hospital for careful observation and control. During the third stage of labor, patients with valvular heart disease or congenital cardiac defects should receive 600,000 units of procaine penicillin and two grams of streptomycin, and these should be continued daily for three days post-partum to avoid bacterial endocarditis secondary to the usual bacteremia associated with delivery. Although in certain isolated cases cardiac surgery may be considered and even performed during pregnancy, in practice its use is rarely necessary.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

VOLUNTEERS PROVE ASTRONAUTS CAN WORK TOGETHER

Ten recent graduates of the Air Training Command's training program ended a month's confinement in a simulated aerospace vehicle at Marietta, Georgia, Monday, August 13, 1962. They participated in a psychological test to determine how long a team of astronauts can work efficiently on prolonged missions into outer space.

This was the second study within three months made for the Air Force's Aerospace Medical Division (Air Force Systems Command) by Lockheed-Georgia Company, a division of Lockheed Aircraft Corporation. The first test ended June 24, 1962.

In the first test, six Air Force Academy men spent fifteen days in the small "space cabin"—with a work area about the size of a station wagon. They worked on monitoring consoles and working mental problems (such as astronauts will face) for four hours and were off duty two hours, around the clock.

With talk of space platforms, relay stations, and long periods away from the earth, however, the Air Force wants to know how a team can do for 30 days or longer.

The larger crew of ten men from the Air Force Training Command spent twice as long as the cadets in the cabin—going in July 14 and coming out August 13, thirty days later. However, they had a more reasonable work-to-rest schedule. They were on duty four hours and off four hours, continually for one month.

Five men were on duty and five were at leisure at all times. The less demanding four-to-four hour schedule provided a safety factor for emergencies that might take

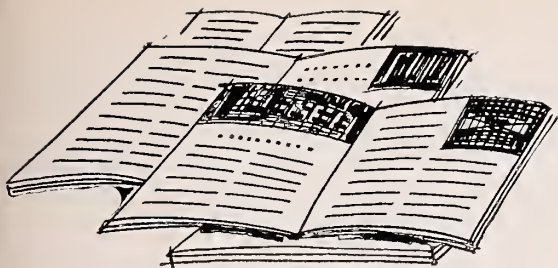
one member of the team of astronauts out of action. Should one member of a six-man crew be out of action on a four-to-two hour schedule, his companions would have only four hours rest per day. This might interfere with their taking over the extra work.

The four-hour on, four-hour off duty test was the first one here in which crew members have had spare time on their hands. In the four-hour work, two-hour rest, the men were so tired they spent their leisure time sleeping.

The men had no idea that the Air Force and Lockheed psychologists would open the door to the 1,100-foot cabin (including work space, leisure area, and bunks) at 8 a.m., Monday. They had anticipated the tests would continue another ten days. They had been told, on entering the cabin, that the tests would run 40 days.

Dr. W. Dean Chiles, Air Force psychologist, and Dr. Earl Alluisi, Lockheed psychologist, said the men were misled about the timing so they would not key up their performance in the "home stretch" of the study. The two studies sought to encourage the men to level off their performance, instead of having peaks and valleys of efficiency. In previous tests, men showed high performance during daytime hours and low performance at night.

The men in the test just ended are from Reese Air Force Base at Lubbock, Texas, and Vance Air Force Base, Enid, Oklahoma.



Disorders in Children of Low Birth Weight

EVIDENCE OF NEUROLOGIC OR OPHTHALMIC DISORDERS was noted in 22 per cent of children surveyed whose birth weight was not more than four pounds.

Cerebral palsy, convulsions, mental retardation, visual defects, and perceptive deafness were among the disorders encountered.

McDonald, A. D.: Neurologic and Ophthalmic Disorders More Common in Children of Low Birth Weight, *Brit. M. J.*, 1:895, 1962.

Acute Pancreatitis in Children

ACUTE PANCREATITIS IS RARE IN CHILDREN. Nevertheless, this condition should always be considered in the differential diagnosis of acute abdominal pain in the pediatric age group. In only a small percentage of reported cases in children are etiological factors clearly recognized. This paper discusses some of the causes, such as, nonpenetrating trauma to the abdominal wall, inflammations, congenital anomalies, obstructions, and the anaphylactic theory. Finally there is a large group of cases in which acute hemorrhagic and necrotic changes are found in the pancreas where the etiology remains obscure. In the pediatric age group this group is unfortunately the largest, and erroneous diagnoses are commonly encountered.

Although occurring infrequently, this disease must be considered in the differential diagnosis of acute abdominal pain and vomiting in children.

Schmidt, D. M.: Acute Pancreatitis in Children, *Clinical Proceedings, Children's Hospital of the District of Columbia*, 15:133, 1962.

Glue-Sniffing

GLUE-SNIFFING, the deliberate inhalation of fumes from plastic and airplane cements, is increasing in incidence among adolescents. This may be considered by some merely as an adolescent craze, soon to be replaced by some other passing fad, and hence of little significance. But unlike other relatively harmless activities, glue inhalation appears to carry with it a potential for significant detriment to the child's physical and emotional health. The volatile, organic

solvents contained in these glues can be toxic to organ systems. Public awareness of the seriousness of this practice can lead to further investigations of the medical, social, and psychological aspects of glue-sniffing, and to its ultimate control.

Glaser, H. H., and Massengale, O. N.: Glue-Sniffing in Children, *J.A.M.A.* 181:90, 1962.

Percutaneous Renal Biopsy Under Direct Radiologic Direction

IT IS POSSIBLE TO OBTAIN DIRECT KIDNEY BIOPSIES by a new safe technique utilizing direct visualization under the image amplifier. The indications for renal biopsy include the need for making a diagnosis of any renal abnormality in which specific therapy depends on exact diagnosis. It is also valuable in prognosis especially in those patients with a nephrotic syndrome. This one is hypertension due to subcapsular renal hematoma. Flank injuries which produce hematuria, such as football injuries, necessitate a follow-up for renal compression by an organized subcapsular hematoma which may produce hypertension. Although the injury may have occurred months prior to the development of hypertension, nonetheless, complete hypertensive investigative studies are indicated.

Ginsburg, I. W., Durant, J. R., and Mendez, L.: *J.A.M.A.*, Vol. 181, No. 3, July 21, 1962.

The Relation of Carcinoma of the Breast and Pregnancy in 283 Patients

NO PROOF COULD BE OBTAINED from this series that the interruption of pregnancy improves the five-year clinical cure rate or increases the survival time in the pregnant patient who develops breast cancer.

Holler, Arthur L., and Farrow, Joseph H.: *S.G.&O.*, Vol. 115, No. 1, July 1962.

Polycythemia in Lung Disease

THE DATA INDICATE that secondary polycythemia developed proportionally to the degree of hypoxia in chronic respiratory disorders of all sorts . . . because the red cell mass is more closely related to the level of hypoxia than is the hematocrit, the existence of a

CLINICAL CONCEPTS / Continued

secondary polycythemia will be recognized more frequently by measurement of the red cell mass. In other words, significant polycythemia may well be present with a normal hematocrit, as was demonstrated by the presence of an elevated hematocrit in only five of the 15 subjects in whom the red cell mass was elevated . . . there was delayed and incomplete incorporation of radioactive iron into the erythrocytes of patients with chronic bronchitis and emphysema.

Lertzman, M., Isreals, L. G., and Cherniack, R. M.: Erythropoiesis and Ferro Kinetics in Chronic Respiratory Disease. *Ann. Int. Med.* 56:821, 1962.

Pigmentation Due to Tetracycline

IN ADDITION TO OTHER SIDE EFFECTS of treatment with tetracycline, intracranial hypertension has been reported. Dark staining of the teeth has also been noted after prolonged administration. In this paper the authors report evidence of skeletal pigmentation. At autopsy all the bones examined in these reports were found to have a striking yellow color. It is suggested that after prolonged administration of tetracycline, the drug may be stored in bone due to a tetracycline hydrochloride calcium phosphate complex.

Hilton, H. B.: Skeletal Pigmentation Due to Tetracycline, *Jour. Cl. Path. (London)* 15:112, 1962.

Electrophoretic Patterns of Serum Proteins in Hepatic Disorders

ELECTROPHORETIC PATTERNS OF SERUM PROTEINS in patients with various hepatic disorders is presented. There was a marked increase of gamma globulins in cirrhosis, both in adult and infantile types. A broad gamma globulin band in paper strips with the disappearance of the usual pale area between gamma and beta bands was observed in all the cases of infantile cirrhosis and may be considered diagnostic. There was a sudden fall of alpha-2 globulin in the patients with acute fulminating infective hepatitis. The possible prognostic signifi-

cance of a low alpha-2 pattern is discussed.

Mathur, K. S., and Agarwal, B. D.: Paper Electrophoresis of Serum Proteins in Hepatic Disorders, *Jour. Indian Med. Assn.* 38:103, 1962.

Birth Characteristics in Children with Malignant Neoplasms

THIS PAPER REVIEWS CERTIFICATES OF DEATH AND birth of a large number of children born between 1947 and 1957 and who died at some time between 1947 and 1958 of malignant disease. Mortality from leukemia was associated both with birth order and with maternal age, risk of death being about 50 per cent higher in first than in fifth and later births, and about 40 per cent higher in children of women over age 40 than in those under 20. No other form of neoplasm showed such a significant association.

MacMahon, B., and Newill, V. A.: Birth Characteristics of Children Dying of Malignant Neoplasms, *Jour. Nat. Cancer Inst.* 28:231, 1962.

Phocomelia

IN 1960 KOSENOW AND PFEIFFER REPORTED A new clinical syndrome; the essential feature was phocomelia. The incidence of the malformations rapidly increased and by the end of 1961, thousands of children had been born with severe malformations of the extremities. The cause of the factor appeared to be an exogenous agent . . . Almost simultaneously Lenz and Hamborg and McBride in Australia suspected that the malformations were caused by taking thalidomide in early pregnancy . . . Thalidomide is a synthetic drug developed by Grunenthal and marketed in Germany as Contergan, in England as Distaval, in Portugal as Softenon, as Kevadon in the United States (though not released by our Food and Drug Administration) and as Kevadon and Kalimol in Canada. It was an excellent sleeping tablet and tranquilizer and was added to a number of other compounds which were used for the relief of grippe, migraine and asthma, and also for expectorants.

Taussig, H. B.: A Study of the German Outbreak of Phocomelia. The Thalidomide Syndrome, *J.A.M.A.* 180:1106, 1962.

NATION'S OLDEST ESSAY CONTEST

The Trustees of America's oldest medical essay competition—the Caleb Fiske Prize of the Rhode Island Medical Society—have announced two subjects for this year's dissertation, open to any Doctor of Medicine in the nation, for which a cash prize of \$500 will be awarded.

The subjects chosen are "Etiological Factors in the

Development of Congenital Anomalies," and "Progress in the Relief of Hearing Defects."

An entry on either subject must be typewritten, double-spaced, and should not exceed 10,000 words. Essays must be submitted by December 11, 1962, to the Secretary, Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.



THE ASSOCIATION

DEATHS

GUY D. AYER, 84, of Atlanta died July 21, 1962, in a private hospital in Atlanta. Dr. Ayer was a graduate of Emory University School of Medicine, where he taught for many years in addition to his private practice.

He was a member of the Fulton County Medical Society, the Medical Association of Georgia, the American Medical Association, the Second Ponce de Leon Baptist Church, the Piedmont Driving Club, and the Ansley Golf Club.

He is survived by a son, Dr. Darrell Ayer, Atlanta, and two grandchildren.

CARL A. KLINE, 32, of Griffin, died of a heart attack recently at his home. Dr. Kline, pathologist at the Griffin Spalding County Hospital, was a member of the Medical Association of Georgia, the Orleans Parish Medical Society, the Louisiana State Medical Society, and the American Medical Association.

He received his medical degree from Tulane University and served his residency at Southern Baptist Hospital, New Orleans, Louisiana.

THOMAS EDWIN McBRYDE, 83-year-old Rockmart physician, died of a heart attack at his home, July 3, 1962. Dr. McBryde, a native of Bibb County, received his medical degree from the Atlanta College of Physicians and Surgeons.

He served as mayor of Rockmart for a number of years, served on the City Council, and was Chairman of the Polk County Board of Commissioners of Roads and Revenues for 12 years. He served as official physician for the Seaboard Railway and the Southern Railway for 40 years, and was a Mason and a Shriner.

In Atlanta in 1952 he was cited by the AMA for 50 years of service.

He is survived by his wife, Elizabeth Casey McBryde, and a stepdaughter, Mrs. Norman Kinnamon, High Point, N.C.

PERSONALS

First District

CHARLES T. BROWN, former director of public health at Statesboro, has accepted the position of medical director of the State Health Department's special services branch. Dr. Brown, who assumed his new duties July 1, 1962, was previously in private practice in Guyton before entering the field of public health in 1959.

BENJAMIN C. WILLS, Savannah psychiatrist, presented slides describing the functions of the Electroencephalograph to the Joe Berg Seminar held in Savannah July 23, 1962.

Speaking at the two-day board meeting of the Woman's Auxiliary of MAG held in July in Americus, was T. A. PETERSON of Savannah.

Appointed county physician by the Chatham Commissioners August 3, 1962, was JOHN E. PORTER of Savannah. Dr. Porter previously served as city physician in Savannah.

CLARENCE W. RAWSON, formerly of Augusta, has begun practice in Savannah in association with T. A. AMBURGEY.

Second District

FRED D. CHENEY, Moultrie, has announced the association of WILLIAM M. NEWTON in the practice of internal medicine.

Third District

E. M. MOLNAR has opened his office in Columbus for the practice of general surgery.

Speaking at a symposium on Clinical Medicine and Surgery sponsored by the Georgia Academy of General Practice and Emory University School of Medicine July 18, 1962, in Atlanta were ARTHUR P. RICHARDSON, Atlanta, and HARRY O'REAR, Augusta.

L. C. CHEVES of Montezuma spent a week in July in Atlanta where he received special training in anesthesiology at Emory University.

A. J. MORRIS has recently become associated in the practice of surgery with CARL P. SAVAGE and L. C. CHEVES, Montezuma.

COLONEL VORIS F. McFALL, who retired from the Air Force July 1, 1962, is now associated with DANIEL NATHAN in the practice of medicine and surgery at Fort Valley.

R. C. PENDERGRASS of Americus was named chairman of the section on radiology by the AMA. His appointment was announced at the annual AMA meeting in Chicago in June.

JAMES H. VENABLE announced in July the opening of his office in Columbus for the practice of Obstetrics and Gynecology.

J. C. SERRATO, Columbus, has been elected as an active member to the Mexican Society of Orthopedic Surgeons.

Fourth District

MORGAN KELLUM, Thomaston, has recently re-

turned from a month's tour of Europe. Dr. Kellum was accompanied by his wife and two sons, and while in London observed some surgery at Guys' Hospital.

W. G. HICKS, Jackson, has announced the reopening of his office for the general practice of medicine and surgery.

JOSEPH A. WILBER, Atlanta, spoke at a two-day Georgia Hypertension Seminar at Georgia Baptist Hospital, July 16, 1962. Also included on the program was J. EDWIN WOOD, Augusta.

T. E. McGEARCHY, past-president of the DeKalb County Medical Society, will serve as a co-district chairman for the Decatur-DeKalb medical-dental division in this fall's United Appeal Campaign.

MURDOCK EQUEN, Atlanta, has announced enlarged parking facilities for the Ponce de Leon Infirmary patients. To provide more parking, an apartment building at 149 Third St., N.E., has been torn down.

GEORGE MIXON, Palmetto, moved September 1, 1962, to Ocilla for the practice of medicine.

In the Sunday Magazine section of the July 15, 1962, issue of the Journal-Constitution, ALBERT RAUBER of Decatur was the subject of an article entitled, "Baby Doctor Creates Little Men." Dr. Rauber's hobby is making and painting, by hand, miniature metal soldiers of various wars.

JOHN T. MAULDIN, Atlanta, has been named chairman of the State Commission on Aging.

ROBERT C. SCHLANT and WADE M. SHUFORD of the Emory University School of Medicine have been awarded a \$5,500 grant by the James Picker Foundation. The grant will be used in developing an X-ray technique for studying the condition of diseased lung and liver blood vessels.

Sixth District

H. D. ALLEN, Milledgeville, was recognized for 25 years service to the Department of Public Welfare at a July meeting of the Welfare Board.

CHARLES L. RIDLEY, JR., Macon, has announced the association of CHARLES RIDLEY WHITE in the practice of general surgery in Macon.

BURCH J. ROBERTS, Macon, was chosen in July to head a newly formed Health District comprising Butts, Clayton, Fayette, Henry and Spalding counties with headquarters at Griffin.

Seventh District

Serving as a co-district chairman of the Cobb County medical-dental division in this fall's United Appeal campaign will be WILLIAM CONNELL PATTERSON, JR., of Smyrna.

JAMES JENKINS, Rome, announced July 22, 1962, the association of RICHARD W. LEIGH in the practice of obstetrics and gynecology at Rome.

HENRY LUCAS is now associated with LESTER MARTENS in the practice of internal medicine in Rome.

C. J. WYATT, JR. announced June 2, 1962, that JAMES H. SMITH will be associated with him at his offices in Rome.

Associated in the general practice of medicine with HUGH A. GOODWIN, Summerville, will be HERMAN SPIVEY.

Eighth District

WILLIAM H. TAILER of Darien is in charge of an obstetrical clinic held the first Tuesday of each month. The clinic began August 7, 1962, at the McIntosh County Health Center.

FRED N. CLEMENTS, JR., Adel, spent a week in July at Asheville, N. C., attending the Southern Obstetric and Gynecology Seminar.

Ninth District

WILLIAM H. WHITE, JR., Gainesville, is now associated with JOHN K. BURNS, III, in the practice of obstetrics and gynecology in Gainesville.

E. W. HOLLOWAY, a native of Americus, is now associated with JOE L. GRIFFITH in general medicine and surgery at Commerce.

GEORGE GOWDER, JR. of Gainesville is now associated with C. J. WALKER in the practice of general medicine.

The Medical Staff of the Habersham County Hospital elected the following officers for the fiscal year beginning July 1, 1962: F. O. GARRISON, Demorest, Chief of Staff; JACK B. EDWARDS, Cornelia, Vice Chief of Staff; and L. G. HICKS, Clarkesville, Secretary.

WILLIAM D. FLOREY became associated July 1, 1962, with the Medical Arts Clinic at Toccoa.

Tenth District

WILLIAM E. BARFIELD, Augusta, has moved from his offices in the Medical Arts Building to 1139 Druid Park Avenue for the practice of gynecology and obstetrics.

J. WELDON WILLIAMS, JR., Lavonia, was officially sworn in for a six year term on the State Medical Board in ceremonies at the State Capitol July 26, 1962.

EXECUTIVE COMMITTEE OF COUNCIL

THE EXECUTIVE COMMITTEE of Council meeting was called to order by the Chairman Thomas W. Goodwin at 4:20 P.M., July 18, 1962, at the Association Headquarters Office Building, Atlanta, Georgia.

Executive Committee members attending were Thomas W. Goodwin, Augusta; Fred H. Simonton, Chickamauga; George H. Alexander, Forsyth; John T. Mauldin, Atlanta; and John S. Atwater, Atlanta. Also in attendance were Mr. John Moore, MAG Attorney; Mr. James Baker, Medicare Administrator; and Mr. Milton D. Krueger, Mr. James M. Moffett and Mrs. Catherine Wooten of the MAG Staff.

Vocational Arts Institute

Mr. Fred Rich, Director, of the Vocational Arts Institute, gave Executive Committee information regarding his school for Dental Assistants and his desire to add a Medical Secretarial course to the curriculum. This was received for information.

Review of Minutes

Mr. Milton D. Krueger reviewed the minutes of the Executive Committee and Council meetings of June 16-17, 1962, and the Telephone Conference Meeting of Executive Committee of July 2, 1962. On motion duly made and seconded the minutes were approved as read.

Treasurer's Report

Dr. Atwater gave the Treasurer's report. On motion duly made and seconded it was voted to approve this report.

Appointment of Special MAG Committee on Georgia Adoption Practices

Deferred for Presidential appointment.

Interprofessional Council Appointment

On motion duly made and seconded it was voted to appoint William A. Wood, Jr., Atlanta, to replace C. J. McLoughlin on the Interprofessional Council.

Medicare Claim

Dr. Mauldin and Mr. James Baker explained the claim submitted by a physician. After discussion it was voted that this claim be reopened and it was suggested that \$150.00 would be a more equitable fee than the previously determined fee of \$50.00. Dr. Mauldin stated that there was a need for a change in the rules and regulations for the adjudication of claims and that it was his opinion that it should be done at the time of the annual State Review Board meeting, and that the decision of the State Review Board regarding adjudication of claims should then be submitted for the approval of the Executive Committee. This suggestion was approved by the Executive Committee.

Due to resignations of two members of the State Review Board, the Secretary was asked to make two appointments to replace them, and to so notify the appointees.

Blue Shield Senior Citizens Plan

After a discussion of the number of replies received from President Goodwin's letter and the Resolution adopted at the June Council meeting, the Executive Committee took cognizance of the fact that there was an insufficient number of delegates' petitions to hold a Special House of Delegates meeting. The results of the mailing to the petitioners were as follows: Out of 26 petitioners there were ten withdrawals, one non-withdrawal, and 15 did not reply. Therefore, of the 26 petitioners with ten desiring withdrawal, there were 16, which was four short of the required number to hold a special House of Delegates meeting.

Tax Allowance on Automobile

Mr. Krueger read the minutes of the September 16-17, 1961, Council meeting and the October 1961, Executive Committee meeting on this item, and also read the MAG Attorney's letter regarding MAG non-participation in the fee the physician would have to pay in order to take an appeal from the decision of the Tax Court of the United States. Mr. Krueger also read a letter from Dr. Lee Battle asking Executive Committee to reconsider their previous decision of non-participation in this case. After receiving the above information and after due consideration, the Executive Committee decided to take no further action in this matter, and to reply to Dr. Battle in this regard.

City-County Ad Valorem Taxes

Dr. Mauldin explained that the County Commissioners had ruled against MAG and asked if it was still the opinion of the Executive Committee that the case should be taken to court. On motion (Alexander-Atwater) it was voted that MAG file

suit to enjoin the tax officials of Fulton County and the City of Atlanta from levying to collect ad valorem property taxes.

Civil Court Case

A motion to dismiss this case was filed by the MAG attorneys. Mr. Moore presented an estimate of attorney's fees for a dismissal and for a summary judgment.

Los Angeles County Medical Association Resolution

Dr. Mauldin read a letter from the Los Angeles County Medical Association regarding a resolution sent by them to the Saskatchewan physicians. This was received for information.

Medical Defense

Mr. Krueger spoke on the appointment of a member on the Medical Defense Committee due to Dr. Charles S. Jones' resignation. On motion (Simonton-Atwater) it was voted that a letter be written over the President's signature to Dr. Jones to ask that he reconsider resigning from this committee. Mr. Krueger also asked Executive Committee for a decision on the payment of \$100.00 to a physician member for medical defense, when that member does not have malpractice insurance. There is one case pending now for decision, and on motion duly made and seconded it was voted to ask Secretary Mauldin to investigate the matter and make a decision in this individual case.

Vandiver Letters

Secretary Mauldin read two letters from Governor Vandiver, one regarding the MAG Resolution sent to Governor and Mrs. Vandiver regarding their efforts in Mental Health; and the other regarding his forthright stand at the Governors' Conference against the President's bill for health care of the aged under Social Security. The Association had thanked him for his actions at the Governors' Conference.

New Business

(1) Dr. Murdock Euen gave the Association an Addressograph plate file and plates. On motion duly made and seconded it was voted to write him a letter of thanks.

(2) Rothberg Offer: This offer to lease or purchase MAG property was turned down. Secretary Mauldin was instructed to write Mr. Rothberg.

(3) AMA Mental Health Meeting: It was suggested that the Chairman of the Mental Health Sub-Committee, Maurice Arnold, be contacted regarding attendance at this meeting, and if he does not wish to attend would he be willing to approve someone in private practice attending the meeting as representative of MAG.

(4) Payne Letter: Secretary Mauldin read a letter from Dr. Rufus Payne, Superintendent of the Eugene Talmadge Memorial Hospital, about submission of claims from the Talmadge Hospital under the MAA program.

(5) Jenkins Request: Executive Committee recommended that a letter be written to Dr. Jenkins stating that he is a member in good standing of the Association.

(6) AMA PR Institute: It was recommended that Linton Bishop, Chairman of the Public Service Board, attend this Institute, and that Mr. Krueger also attend. This meeting is to be held August 30-31, Chicago.

(7) Bibb County Medical Society Invitation: Secretary Mauldin was instructed to write Bibb County Medical Society a formal acceptance of their invitation to hold the 1964 Annual Session in Macon.

(8) Watters Editorials: Received for information.

(9) Recodification of Public Health Laws: Discussed.

(10) State Medical Education Board: Frank Wilson, Leslie, having been appointed by Dr. Atwater, Chairman of the Special Activities Board, to work as liaison between MAG and the State Medical Education Board, is to be notified to work with the State Board on medical placement.

(11) Date and Site of August Executive Committee meeting: August 19, 1962, 10:00 A.M., MAG Headquarters Building, Atlanta.

(12) Telegrams to Senators Talmadge and Russell: President Goodwin received endorsement from the Executive Committee to officially thank Senators Talmadge and Russell for the position they took on the Anderson-Javits Amendment.

There being no further business the meeting was adjourned at 6:40 P.M.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Brownsberger, John F.	Lakeland, Ga.	Active	South Georgia
Davis, F. Morris	820 Tift Avenue Tifton, Ga.	Active	Tift
Flanders, Charles D., Jr.	1308 Church Street Marietta, Ga.	Active	Cobb
Garrett, Sydney A.	Dalton-Garrett Clinic Hartwell, Ga.	Active	Franklin-Hart- Elbert
Gillespie, Charles B.	80 Butler Street, S. E. Atlanta 3, Ga.	DE 2	Fulton
Hallman, Helen W.	Suite 3, 82 Baker St., N. E. Atlanta 3, Ga.	Active	Fulton
Martinez, A. B.	Milledgeville State Hospital Milledgeville, Ga.	Active	Baldwin
May, Robert W., Jr.	136 W. Main Street Cartersville, Ga.	Active	Bartow
McRae, Luther C., Jr.	Box 378 Glenwood, Ga.	Active	Southeast Georgia
Nichols, Joseph J.	20 First Street, S. W. Moultrie, Ga.	Active	Colquitt
Osteen, Clark L.	11-A Medical Arts Center Savannah, Ga.	Active	Georgia Medical
Parsons, Richard C.	559 Medlock Road Decatur, Ga.	Active	DeKalb
Paulk, E. Alan, Jr.	80 Butler Street, S. E. Atlanta 3, Ga.	DE 2	Fulton
Pike, Benjamin L.	15 Medical Arts Center Savannah, Ga.	Active	Georgia Medical
Proctor, Herbert D.	Box 253, 80 Butler Street, S. E. Atlanta 3, Ga.	DE 2	Fulton
Sessions, George P.	2701 North Decatur Road Decatur, Ga.	Active	DeKalb
Tarnasky, Ralph E.	Macon Hospital Macon, Ga.	Active	Bibb
Thomas, R. P.	Medical College of Georgia Augusta, Ga.	Active	Richmond
Threlkeld, William A., Jr.	218 Magnolia Drive Thomson, Ga.	Active	McDuffie
Uehling, Edward R.	2910 N. Druid Hills, N. E. Atlanta 6, Ga.	Active	DeKalb
Wilson, William J.	Elberton, Ga.	Active	Franklin-Hart- Elbert
Woodard, Otis J., Jr.	234½ Pine Avenue Albany, Ga.	Active	Dougherty

How well are we
telling our story?

See Pages 502 and 505

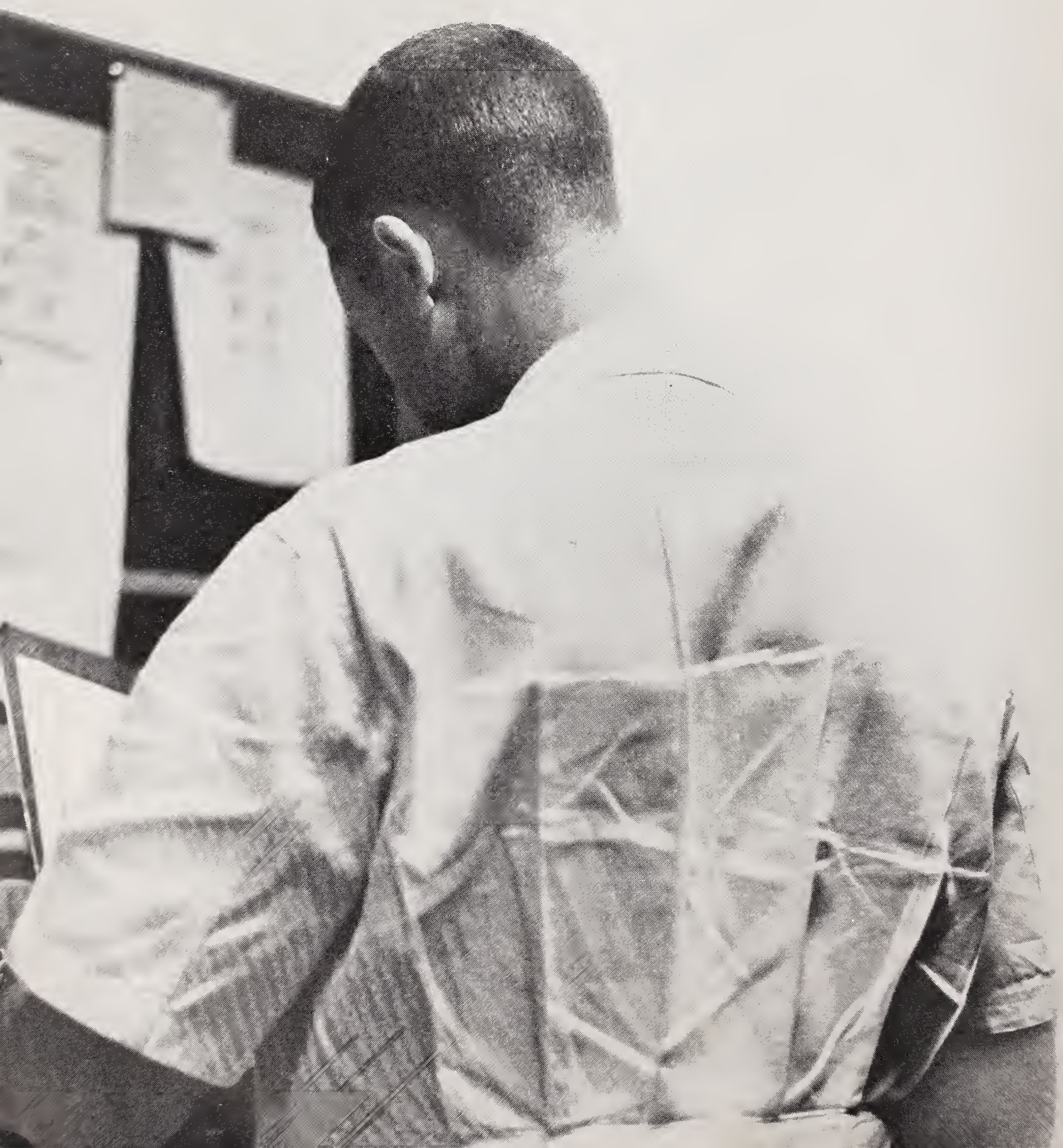
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JOURNAL OF THE MEDICAL ASSOCIATION *Georgia*

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Design: John Stuart McKenzie, *Atlanta*

The stars on the map of Georgia represent the location of speeches given by doctors to laymen's groups in the last six months. Watch for the feature, "How Well Are We Telling Our Story?" in future issues of the *JMAG* to see what kind of communication job the doctors in your community are doing.

Specialty Societies

Georgia Heart Association

- A. Calhoun Witham, Medical College of Georgia, Augusta, *President*
J. Willis Hurst, Emory University Hospital, Atlanta 22, *Secretary*
Mr. Linwood Beck, 58 Balto Place, N.W., Atlanta 9, *Executive Secretary*

Georgia Pediatrics Society

- Joseph H. Patterson, 1405 Clifton Road, N.E., Atlanta (22), *President*
L. C. Antrobus, 3130 Maple Drive, N.E., Atlanta 5, *Secretary*

Georgia Society of Ophthalmology and Otolaryngology

- T. S. Burgess, Strickler Building, Atlanta, *President*
James T. King, 340 Boulevard, N.E., Atlanta 12, *Secretary*

Georgia Association of Pathologists

- L. H. Campbell, 548 First Street, Macon, *President*
John T. Godwin, 265 Ivy Street, N.E., Atlanta 3, *Secretary*

Georgia Society of Anesthesiologists

- E. L. Rushia, University Hospital, Augusta, *President*
Frederick A. Carpenter, 89 Butler Street, S.E., Atlanta 3, *Secretary*

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- Lee Battle, 321 W. 7th Street, Rome, *President*
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Georgia Radiological Society

- George W. Brown, Griffin, *President*
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Georgia Thoracic Society

- James L. Alexander, 104 E. Gwinnet Street, Savannah, *President*
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Mr. Carl Fox, 5 Forsyth Street, N.W. 3rd Floor, Atlanta, *Exec. Secretary*

Georgia Psychiatric Association

- Sidney O. Isenberg, 101 3rd Street, N.E., Atlanta, *President*
Sheldon B. Cohen, Medical Arts Building, Atlanta 8, *Secretary*

Georgia Society of Dermatologists

- Marvin F. Engel, 2001 Gloucester Street, Brunswick, *President*
R. M. Reifler, 729 Pine Street, Macon, *Secretary*

Georgia Academy of General Practice

- Charles McArthur, Cordele, *President*
M. Freeman Simmons, 380 W. Ponce de Leon Avenue, Decatur, *Secretary*

Georgia Society of Internal Medicine

- Edward L. Bosworth, Harbin Clinic, Rome, *President*
J. S. Wilson, 1938 Peachtree St., N.E., Atlanta, *Secretary*

American College of Physicians

- Sterling Claiborne, 384 Peachtree Street, N.E., Atlanta 8, *President*
(Georgia governor)

MANAGEMENT OF THORACIC SURGICAL EMERGENCIES IN INFANTS

Robert G. Ellison, M.D., and William E. Laupus, M.D., *Augusta*

■ ***Because of the natural high mortality
rate in this group, surgical relief of the
mechanical abnormality is urgent***

THORACIC DISEASES ARE RESPONSIBLE for many emergencies in infants that require surgical alleviation. Most of these mechanical abnormalities are of congenital origin, but certain acquired diseases also produce serious effects. Time does not permit a complete review of all emergencies of thoracic origin that might be benefited by some surgical intervention. The purpose of this presentation is to present a surgical philosophy in regard to management of the more common types of thoracic emergencies that have been encountered at the Eugene Talmadge Memorial Hospital. An aggressive attitude is essential because many of these problems are so distressing that the infant will not survive unless something is done to relieve the basic disturbance in physiological alterations. At the same time, the approach is conservative in that under certain circumstances palliative or staged procedures are recommended with the viewpoint that a higher survival rate can be anticipated and complete correction of the defects can be accomplished when the child has reached an age and size that is consistent with a more extensive surgical procedure. Emphasis will be placed upon the surgical approach to these problems.

Non-Cardiac Problems

The chief problem under consideration is treat-

ment of the infant with respiratory distress with and without cyanosis. Exclusive of congenital heart disease, some of the more common causes of this clinical picture to be considered are pneumothorax, diaphragmatic hernia, congenital cyst, lobar emphysema and tracheo-esophageal fistula. *Pneumothorax*, associated with mediastinal emphysema, may make its appearance soon after birth due to rupture of alveoli along vessels within the lung parenchyma. Air rapidly traverses perivascular planes to enter the mediastinum and may accumulate in such massive amounts as to rupture into the pleura with the development of a pneumothorax.¹⁵ This mechanism may be initiated by difficulties in resuscitation, coughing, or straining of the infant. At the same time, it may exist in association with any respiratory infection so that it may develop after a few weeks or months of age. Respiratory distress may occur under such circumstances even in the absence of pneumothorax as a result of the massive pneumomediastinum^{10,12,13} and this can be readily alleviated by simple needle aspiration of the anterior mediastinum or closed thoracotomy with catheter.

A more common cause of respiratory insufficiency associated with pneumothorax is that seen as a result of staphylococcal pneumonia and rupture of a cavity into the pleura with the development of *acute tension pyopneumothorax*.^{1,10,16,21} Under such circumstances, treatment is directed primarily toward relief of the tension pneumothorax and consists

From the Division of Thoracic Surgery and Department of Pediatrics, Medical College of Georgia, Augusta.
Presented at the 108th Annual Session of the Medical Association of Georgia, May 6, 1962, Savannah, Georgia.

simply of closed thoracotomy by insertion of a number 16 or 18 French catheter, usually into the second or third intercostal space anteriorly and connecting it to a water seal bottle. Ordinarily this leads to prompt expansion of the lung, but in some cases, where the empyema is the major problem, multiple catheters are necessary. Not infrequently, as the lung re-expands, one or more parenchymal cavities are noted and often the question arises whether or not these represent loculated pleural spaces or whether or not they represent intra-parenchymal cavities. In most cases, they represent cavities or spaces within the lung, and it should be emphasized that no therapy is needed in order to eradicate them. With the passage of time, these spaces usually disappear and do not require any surgical treatment.

Diaphragmatic hernia also represents a serious problem in infancy leading to a mechanical ventilatory insufficiency as a result of collapse of the ipsilateral lung and displacement of the mediastinum to the contralateral side.^{8,22} The foramen of Bochdalek hernia, located posterolaterally in the diaphragmatic leaf, occurs more commonly on the left side. On the right side it is less serious because of the protection against herniation of the intra-abdominal viscera afforded by the liver. The presence of a hernial sac renders the defect of less significance because it protects the abdominal viscera against massive herniation. More commonly a sac is not present. These babies often are in extreme distress with labored respiration, and cyanosis and mechanical relief of the ventilatory impairment is urgent. This can probably be accomplished more rapidly by means of a transthoracic exposure, and mechanical relief results as soon as the thorax is open. It has been our experience that more satisfactory exposure and repair can be accomplished by a transthoracic approach. Also an opportunity is provided to evaluate the status of the ipsilateral lung which is often hypoplastic. On the other hand, reduction of the intestines through the diaphragmatic ring may be difficult, particularly in view of the relatively small size of the peritoneal cavity. While our viewpoint is to favor the transthoracic approach, in the case of a critically ill infant, perhaps a wiser course is a rapid laparotomy with a pulling down of intestines from the thorax through the defect into the peritoneal cavity.

Symptoms of *congenital cyst*, usually manifested within a few hours or days after birth, are also due to mechanical ventilatory insufficiency.^{14,17} Asymptomatic cystic parenchymal spaces are not surgical problems and there is some evidence to believe that with the passage of time they will disappear.⁴ It is not at all clear whether those that disappear are true congenital cysts, lined with cuboidal or columnal

type epithelium or whether perhaps these fall into a type of pulmonary air space or pneumatocele that might have resulted from rupture of alveoli associated with pulmonary infection or perhaps at the time of resuscitation at birth. In the case of a tension cyst, the temptation is strong to attempt decompression by means of needle aspiration and on occasion this may be worthwhile. At the same time, one should readily understand the dangers of such a maneuver in that aspiration of the cyst might immediately relieve the situation but within a short period of time thereafter, the patient might be in difficulty as a result of tension pneumothorax due to leakage of the air from the cyst into the pleural space. In the event that needle aspiration is carried out, facilities should be available for immediate thoracotomy and removal of the cyst.

Lobar emphysema is being recognized with increasing frequency in infancy.^{2,7,23} The etiology of this condition is not clear, but frequently atrophy and segmentation of cartilagenous rings to the particular lobe are present producing bronchial obstruction which presumably is the basis for the emphysema. In other cases, redundant flaps of bronchial mucosa have been found and were thought to be responsible for obstruction. The symptoms are similar to those commonly encountered in congenital cyst and usually occur without evidence of respiratory infection. Associated pneumothorax may be present. As a rule, the abnormality is localized to an upper lobe, although more extensive involvement has been reported. As in the case of congenital cyst, removal of the emphysematous, spongy lobe is urgent and frequently is lifesaving.

Congenital esophageal atresia with or without tracheo-esophageal fistula is a common and serious abnormality.⁹ Many of these infants are premature and there is a high incidence of associated congenital anomalies. Fortunately, the most common variety of esophageal atresia is that with the upper blind pouch and the fistula communicating between the distal end of the esophagus and the tracheobronchial tree. Diagnosis usually can be established by the routine passage of a No. 8 French catheter intranasally into all newborn infants. The less common varieties will not be detected by this means but may be suspected by manifestations of symptoms of pulmonary infection and can be confirmed by the installation of contrast media into the esophagus. In the absence of associated anomalies, when the diagnosis of the more common variety is established within 48 hours in a full-term infant, then the morbidity and mortality of the one stage repair are very low. On the contrary, delayed diagnosis, prematurity, associated anomalies, or atelectasis place these babies in a critically ill category and it is felt that a more conservative approach by staging the surgery will lead to a lower

morbidity and a higher survival rate.¹¹ This consists of a preliminary gastrostomy under local anesthesia and ligation of the fistula extrapleurally. Thereafter, the infant is placed in an upright position with a nasopharyngeal catheter inserted down into the upper blind pouch with suction in order to prevent aspiration of secretions. By this means, the infant's general clinical status can be anticipated to improve with clearance of the respiratory infection, and shortly thereafter definitive repair by end-to-end anastomosis can be performed. The associated congenital anomaly may prove at this time to assume increasing importance, and if necessary, repair of the tracheoesophageal fistula can be deferred indefinitely. By staging the surgical approach to these more complicated lesions, a much higher survival rate can be anticipated.

Congenital Heart Disease

It has been estimated that each year in the United States some 30,000 to 50,000 babies are born with some variety of congenital heart disease. A significant proportion of these infants die within the first year of life, the large majority during the first six months. Most of those who succumb have surgically correctable defects. Ordinarily, when an infant is in difficulty within the first year of life as a result of congenital heart disease, the chances of long survival without surgery are extremely poor. While some still cannot be helped by surgical means, the great majority can be palliated if not completely corrected by some surgical procedure.⁶ With these facts in mind an aggressive attitude must be taken toward the early diagnosis and surgical attack upon the infant who is in difficulty from his congenital defect during the first year of life.^{5,20} Particular emphasis is to be placed upon the non-cyanotic group since most of these can be completely corrected and if they cannot be corrected during infancy, palliative procedures can be performed so that more definitive and corrective procedures can be accomplished at a later date.

Patent ductus arteriosus in infancy may not manifest the usual characteristic clinical picture seen in older children. The continuous machinery-like murmur is not usually audible because of the lack of pressure differential between the systemic and lesser circulations. Patent ductus is not infrequently associated with ventricular septal defect so that the possibility of such an associated anomaly should always be considered in a patient with a left-to-right shunt. In older infants and children with a characteristic murmur, diagnostic studies such as catheterization and aortography are not essential, but in the infant where the clinical picture is not clear, retrograde brachial arteriogram may be performed with the establishment of the diagnosis. If an infant is asymp-

tomatic and has a small heart, then surgery may be safely delayed until the baby is 12 to 18 months of age at which time ligation of the ductus can be satisfactorily performed. On the other hand, if the heart is enlarged and if the baby is symptomatic, surgery is urgent because of the high mortality as a result of heart failure in this group of individuals. Usually in such cases, simple ligation is performed and division with suture technique, which is utilized in older individuals, is not necessary.

Ventricular septal defect is another congenital defect encountered commonly in infancy. It is estimated that ten per cent of babies with ventricular septal defects will manifest failure within the first year of life. Our usual policy is to treat such infants intensively by medical means. If favorable response to such therapy follows and is maintained, watchful waiting is the usual policy. Such babies are then kept under observation until they reach an age and size consistent with definitive repair by open technique with the heart-lung machine. On the contrary, if compensation is maintained with difficulty, usually long survival does not follow unless something is done to reduce the strain on the heart due to the tremendous left-to-right shunt. Such infants are less than ideal candidates for complete correction with the heart-lung machine and the usual procedure is to carry out a palliative procedure consisting of the Muller banding of the main pulmonary artery.¹⁸ Reduction in size of lumen of the main pulmonary artery decreases pulmonary blood flow and permits regression of edema and vascular changes. This relatively simple procedure is performed under light anesthesia with a small incision in the third left anterior intercostal space. Direct measurements of pulmonary artery and aortic pressures usually reveal them to be essentially equal. The pulmonary artery lumen is narrowed until distally the pressure is just above normal. Such a procedure is tolerated reasonably well with a mortality much lower than complete correction of the ventricular septal defect with the heart-lung machine and prepares the infant for the more definitive procedure at a later date.

Coarctation of the aorta is a serious abnormality but usually surgical correction can be safely deferred for the optimal age of ten or twelve. At this time, the coarctation can be resected with anastomosis between the two ends. If an infant demonstrates heart failure during the first year of life, his chances of reaching the optimal age are extremely poor. Most reports indicate that if the infant demonstrates evidence of failure his chances for long survival are best if surgical correction is carried out promptly. This is particularly true if patent ductus arteriosus is associated with the coarctation and even more so if the coarctation is of the pre-ductile type.¹⁹ The infants

with coarctations that have come to our attention have all been critically ill babies with tremendous cardiomegaly. It has been our policy to proceed with surgical correction. The objection to repair at this age is that there might not be satisfactory growth of the anastomosis so that when the child reaches an adult size there may be a relative narrowing at the site of the anastomosis necessitating reoperation.

Vascular rings due to abnormalities in development of the aortic arch are seen occasionally in infants and should be suspected in the presence of stridor, dyspnea and recurrent respiratory infections dating soon after the onset of birth. The most common types are double aortic arch, right aortic arch with left ligamentum arteriosum or an anomalous subclavian artery arising from the upper descending thoracic aorta.⁸ As a rule, diagnosis can be established by means of an esophagogram demonstrating compression of the ring against the esophagus, but on occasion tracheogram or retrograde arteriogram through the left brachial artery may be necessary in order to visualize the vascular channels involved. These babies often are in great distress and should be operated upon promptly with division of the constricting vessel.

Tetralogy of Fallot is a common type of congenital heart defect which produces symptoms in infancy as a result of decreased pulmonary blood flow and associated hypoxia. The frequency of hypoxic attacks depends upon the severity of impairment in pulmonary blood flow. Ideally, such an infant is kept under observation until he reaches an optimal age for complete correction, consisting of closure of the ventricular defect and excision of the pulmonary stenosis utilizing the heart-lung machine. This ideally is done when the child reaches an age in excess of five years. Unfortunately, many infants and children are in difficulty prior to this age and something has to be done in order to relieve the hypoxia. Complete correction with the heart-lung machine is not feasible in this young age group and for this reason a shunting procedure is still considered to be a very valuable and desirable operation.^{5,20} There are a number of procedures that can be performed in order to improve the pulmonary blood flow. The Brock procedure is designed to excise, by closed methods, the infundibular stenosis in order to increase the blood flow directly through the main pulmonary artery. Another procedure that has been popularized in recent years is the anastomosis between the right superior vena cava and right pulmonary artery (Glenn operation). The other two procedures that have been commonly used are anastomosis between the subclavian and pulmonary arteries (Blalock) and between the aorta and pulmonary artery (Potts).

The Blalock operation is preferred because it can be taken down more easily when complete correction is performed later, but often in infants the Potts operation is done because of inadequate size of the subclavian artery.

Pulmonic valvular stenosis, often associated with an atrial septal defect, not infrequently presents a clinical picture indistinguishable from that of tetralogy of Fallot. The problem is not only to increase the pulmonary blood flow but also to relieve the tremendously high right ventricular pressure. Since the surgical approach is different from that of the tetralogy of Fallot, it is important to differentiate between the two and for this reason diagnostic studies, usually angiocardiology, are necessary in order to establish the specific type of lesion that is present. In this group, too, our preference is to defer surgical attack, if possible, in order to carry out a complete correction at a later date with the heart-lung machine, but if the infant is in serious trouble, regardless of age he is operated upon by a closed transventricular pulmonary valvulotomy with relief of obstruction at the pulmonary valve. At this time nothing is done about the atrial septal defect. On occasion this procedure has led to complete relief of cyanosis and elimination of polycythemia.

Transposition of the great vessels is recognized as one of the more common forms of cyanotic heart disease and is particularly serious because there is no satisfactory technique for correction at this time. Several techniques have been utilized for total correction, but at this time survival by the various techniques recommended is so poor that they are not routinely advised. Survival of an infant with transposition of the great vessels for any period of time implies the presence of a ventricular septal defect that will allow some degree of mixing of blood between the two systems. Longest survival is in the case that has some degree of pulmonary stenosis because of the protection afforded the lung fields from excessive pulmonary blood flow. At the same time, the pulmonary stenosis may be of such severity that inadequate pulmonary blood flow results. Our policy in transposition is to carry out palliative procedures, first of all to improve the mixing of blood between the two systems and if pulmonary stenosis exists, to carry out a shunting procedure to improve the pulmonary blood flow. These techniques consist of creation of an extracardiac atrial septal defect (Blalock-Hanlon)³ and if the shunting procedure is needed, this may be either a subclavian-to-pulmonary artery anastomosis (Blalock) or an aortic-to-pulmonary artery (Potts) anastomosis, depending upon the size of the infant. While the mortality of any type of surgical procedure in this type of disease is high, these techniques have led to worthwhile palliation in a certain number of infants.

Other types of congenital cardiac lesions that are seen less commonly are aortic stenosis and total anomalous pulmonary venous drainage. Both of these abnormalities are such that they can be helped only by open methods with the heart-lung machine. While these defects are not seen very commonly, it is felt that since they can be corrected only by open means with the heart-lung machine, chances of survival are better if repair can be deferred until they reach a size at which open correction can be carried out more safely.

Summary

Some of the most common varieties of thoracic emergencies in infants that may be benefited by surgical means have been reviewed and an expression of a surgical philosophy presented. It is emphasized that in view of the natural high mortality in this infant group, surgical relief of the mechanical abnormality responsible for the basic physiological disturbance is urgent. In the critically ill infant or in the more complicated type of disease a conservative approach is suggested consisting of staged procedures in the interest of survival of the baby and with the idea of performing more definitive and complete correction at a later date.

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A SHORT HISTORY OF DIABETES MELLITUS

Fredric M. Simowitz,* *Augusta*

■ An historical outline of an increasingly important disease

The Ancient Era

THAT DIABETES MIGHT HAVE BEEN KNOWN as a clinical entity as far into antiquity as 1500 B.C. is indicated by the mention in the Papyrus Ebers¹ of a syndrome having polyuria as its foremost characteristic. That manuscript also described numerous treatments "to regulate the too excessive urine," the following being typical:²

Branches of Qadet plant	1/4
Grapes	1/8
Honey	1/4
Berries from uan tree	1/32
Sweet beer	1/6

Cook: filter and take for two days

There is more convincing evidence that Hindu men of medicine were familiar with the disease. The work *Charaka Samhita*,³ which probably dates slightly more recently than Ebers' Papyrus, describes several types of polyuria, some caused by phlegm, some by bile and some by air. In one of those caused by air the urine is described as "limp and . . . sweet as honey." There is further described "flabbiness of the flesh . . . dryness of the throat . . . and the attraction of ants by urine." There is also indication that the diabetes referred to is the variety we know as diabetes *mellitus*.

Certainly the followers of Hippocrates must have known something of diabetes, but no documentary evidence of such has yet been discovered. A number of the later Greek physicians, however, vividly described diabetic symptoms and offered suggestions for treatment of the affliction. Apollonius (230 B.C.) is generally credited with naming the disease.⁴

The word has its roots in the Greek "dia" (through) and "betes" (flowing), describing the polyuria characteristic of the malady.

According to Gordon,⁴ neither the Greeks nor the Egyptians differentiated between diabetes mellitus and diabetes insipidus, and their descriptions seem to have dealt mainly with the insipid form. The best Greek description of diabetes is probably that of Aretaeus (3rd Century A.D.) who called it "a strange affection . . . being the melting down of the flesh and limbs into urine," wherein "the patients never stop making water, but the flow is incessant, as if from the opening aqueducts." He describes the patient as "thirsty as if scorched with fire." ⁵ Aretaeus' suggested treatment was intended to "strengthen the stomach which is the foundation of the thirst." The following agents were advised: ". . . mastich, dates, and raw quinces." The "water used as drink is to be boiled with autumn fruit. The food is to be milk, and with it cereals, starch, groats of spelt, gruels." ⁶ This regime bore some similarity to that described in the Papyrus Ebers, though it is quite unlikely that Aretaeus knew of that document.

The Arabian writer Rhazes (860-932 A.D.), probably most famous for his classic descriptions of smallpox and measles, likened diabetes to intestinal dysentery, which he held was due to a supernatural heat of the bowel and loss of the ability to retain its contents.⁷ A later Arabian, Avicenna (980-1037 A.D.), offered his ideas on the treatment of Rhazes' "dysentery" of the urinary tract. His management was aimed at reducing the flow of fluids to the kidneys and included the administration of emetics and the performance of daily exercise, specifically horseback riding.⁸ Avicenna favored venesection in

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selected cases, thus supporting the teachings of the Greek surgeon Archigenes.

The Dark Era

The period from the 11th to the 17th century might be called the "dark age of diabetes." If the physicians of that time were familiar with the entity, they certainly left naught for posterity. Gordon attributes this lapse to the loss of the writings of the Hindu surgeon Susruta.

The Renaissance

The rebirth of interest in diabetes occurred during the middle of the 17th century with the work of Thomas Willis, who is credited also with describing the Circle of Willis. He transferred the blame for diabetes from the kidneys to the blood. He frequently is given the dubious honor of being the first to describe the sweet taste of the urine of diabetics ("the urine . . . was wonderfully sweet, as if it were imbued with honey or sugar."), though, as indicated earlier, this fact was known to the ancient Hindus. In his work *Pharmaceutice Rationalis*,⁹ Willis offered the following:

Those labouring with this Disease, piss a great deal more than they drink, or take of any liquid aliment; and moreover they have always joyned with it continual thirst, and a gentle, and as it were hectick Fever.

It no way pleases us that some do assign for the cause of the Diabetes, the attracting force of the Reins: . . .

Wherefore we believe the Diabetes to be rather and more immediately an affection of the Blood than of the Reins, and to take from thence its origin. . . .

Willis attributed the cause of this "affection of the Blood" to the excessive drinking of beer, cider and wine, and to certain complicated predisposing physiologic factors. As to treatment, Willis states that "its cause lies so deeply hid and hath its origin so deeply remote," that "it seems a most hard thing to draw propositions for curing."

The Modern Era

I.

The modern history of diabetes began in Liverpool, England, in 1776. Matthew Dobson, physician to the Liverpool infirmary, demonstrated by evaporating diabetic urine that it contained sugar.^{10,11} Prompted by Dobson's work, John Rollo, surgeon general of the British Royal artillery and the first to demonstrate hyperglycemia in diabetics,¹² attempted control of diabetes through limiting the dietary intake of sugar.¹³ Unfortunately, Rollo abandoned his methods after a few unsuccessful efforts, and research in the management of diabetes mellitus also

was abandoned for the next hundred years.

In 1889, Russian physiologist Oskar Minkowski pancreatectomized a dog shortly after an argument with his colleague, J. von Mering, as to whether an animal could survive extirpation of the pancreas. Soon after surgery, the dog began urinating with abnormal frequency, and flies began to gather around the urine. Minkowski analyzed the urine and found it to contain five per cent sugar. Following a complete study of the phenomenon, Minkowski and von Mering published these comments:¹⁴

After complete removal of the organ the dogs became diabetic. It has not simply to do with a transient glycosuria, but a genuine lasting diabetes mellitus, which in every respect corresponds to the most severe form of this disease in man. If the pancreas is only partly extirpated, diabetes does not follow.

Mering and Minkowski described polyuria, glycosuria, hyperglycemia, acidosis, loss of strength, thirst and hunger in pancreatectomized dogs. "With an extraordinary greediness, they threw themselves at any time upon the food which was offered them, even when they had, only a short time before, been amply fed, and all the time they looked around for every drop of water they could get hold of."

Following the work of Mering and Minkowski, interest heightened and progress was rapid. In 1900, an American pathologist, Eugene L. Opie, described degeneration of the pancreatic islands of a young girl who had died of diabetes.¹⁵ Opie's study prompted the British physiologist, Edward Sharpey-Schafer, to theorize that these islands, first described by the German pathologist, Paul Langerhans, secreted a substance which influences carbohydrate metabolism; to this substance he gave the name insulin.¹⁶ The year was 1916. The stage was set.

The Modern Era

II.

In 1916, Frederick Grant Banting received his M.D. degree from the University of Toronto. Following three years' service with the Canadian Army Medical Corps, during which time he was decorated for gallantry in combat, he returned to Toronto for a year's residency training in surgery. In the summer of 1920, he began the private practice of orthopedic surgery in London, Ontario. Banting's dissatisfaction with private practice was evident in his statement, "after observing the conventional office hours of 2 to 4 p.m. and 6 to 8 p.m. for 28 consecutive days, my first patient presented himself. At the end of the month I had four dollars on the books."¹⁷

In the fall of 1960, Banting accepted an appointment to the faculty of the University of Western Ontario as a demonstrator in anatomy and physiology.

One night, while preparing a lecture concerning the relationship of the pancreas to diabetes, he chanced to read a report by Dr. Moses Baron of the University of Minnesota, describing a rare case of pancreatic lithiasis in which there was marked atrophy of all the pancreatic tissue except for the islands of Langerhans.

"After reading the article by Baron," related Banting, "I was unable to sleep. There seemed to be a means of attacking the problem of extracting the islet cells by ligating the pancreatic duct. It was not until two o'clock in the morning that I was able to crystallize the idea into a form that would lend itself to experimentation. At this hour I arose and wrote in my notebook, the following words—'Ligate pancreatic ducts. Wait six to eight weeks for degeneration. Remove the residue and extract.'"¹⁷

Seeks Advice

Because of limited laboratory facilities at Western Ontario, Banting sought the advice of Dr. J. J. R. Macleod, Professor of physiology at the University of Toronto. Dr. Macleod was somewhat less than encouraging. Said Banting, "I shall never forget that first interview with Professor Macleod. Evidently my case was poorly presented, because at the end of the interview the Professor asked me what I hoped to accomplish when the best trained physiologists had not succeeded in establishing or proving that there was an internal secretion of the pancreas."¹⁷

Nonetheless, Macleod provided him with working space, animals, materials and an assistant—an enthusiastic graduate student named Charles H. Best.

"We formed a partnership," Best stated, "which was based on the new knowledge and experience which we gained together. We had no stipends, but the facilities of Professor Macleod's deserted department were at our disposal. We worked completely alone during the four summer months of 1921 without any verbal or written advice from any senior investigators and until well after the salient facts, consistent dramatic lowering of blood and urinary sugars and complete recovery of our moribund depancreatized dogs had been repeatedly demonstrated."¹⁸

Best's statement was greatly oversimplified. Early attempts to achieve pancreatic degeneration failed because too tightly-bound ligatures caused exudation and recanalization over the ligatures. Eight months after the birth of the idea and two months after actual commencement of experimentation, they had obtained a suitably atrophied pancreas. From this they obtained a saline extract, which, on July 27, 1921, they injected into the blood of a moribund,

surgically-diabetic dog. Within two hours, the clinical condition of the dog had improved markedly and the blood sugar had fallen dramatically.¹⁹

"Our results," Best said recently, "of the effect of insulin on blood sugar and urine sugar of depancreatized dogs were not preliminary in nature as one poorly informed or misguided individual has suggested, but were actually final and conclusive."²⁰ One era had ended; another had begun.

The Insulin Era

Since 1921, hundreds of investigators have made significant contributions to the history of diabetes. Much of their energy has been directed toward the study of the enigmatical subject of carbohydrate metabolism. There also has been a great deal of work designed to improve methods of extracting and purifying insulin, and to produce sustained action forms of insulin. A detailed account of the contributions of these workers would be fascinating, but beyond the scope of this treatise. For the sake of completeness, however, brief notations of some of their accomplishments are in order.

A notable landmark, indeed, is the work of Carl and Gerti Cori on the pathways of the glycogen cycle and their discovery of the enzyme phosphorylase.²¹ One must acknowledge also the contributions of B. A. Houssay,²² who proved that diabetes produced by excision of the pancreas could be ameliorated by hypophysectomy, thus opening the field of research on the interrelation between anterior pituitary and pancreatic hormones. F. G. Young was the first to demonstrate permanent metahypophyseal diabetes by injecting pituitary extract into normal dogs.²³

It would be remiss to fail to mention the monumental work of F. M. Allen and Elliott Joslin in the field of dietary control of diabetes. Their basic plans of therapy have not been abandoned with the advent of insulin, but rather, have continued to the present time.

New Period Opens

A new period in the history of diabetes was opened with the discovery of glucagon. Its presence in islet cell extract was first suggested by Collens and Murlin,²⁴ and was later proven by Burger.

The preparation of crystalline insulin by Abel²⁵ in 1926 marked the beginning of a series of developments which were to make insulin available in purer, more easily utilized forms. Hagedorn produced the first long-acting insulin by adding protamine, to which Scott and Fisher added zinc, thus producing an even more sustaining effect.²⁰ Hagedorn returned to the fore with NPH insulin, and shortly thereafter the lente insulins were developed by Hallas-Moller.²⁰

The recent development of oral antidiabetic agents has added to the physician's armamentarium. Although they have not replaced insulin, these drugs provide effective control of selected cases of diabetes.

From ancient speculation to medieval negligence, from renaissance prejudice to modern boldness, this is the history of diabetes mellitus. After three thousand years the disease has been controlled; soon, perhaps, it will be mastered.

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CLINICAL CENTER STUDY OF GLYCOGEN STORAGE DISEASE

The continued cooperation of physicians is requested in the referral of patients with glycogen storage disease for a study currently in progress at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Patients known or suspected of having one of the forms of glycogen storage disease are needed for further study of metabolic errors leading to this group of disorders and for the elaboration of methods for the prevention and treatment of these conditions.

It is desirable that the diagnosis be established by means of enzymatic assays of liver and muscle tissue obtained by surgical biopsy. However, patients who fit the clinical criteria for diseases due to deposition of glycogen but who have not had a biopsy taken, will also be considered.

In Type I* due to glucose-6-phosphatase deficiency (von Gierke's disease) there is hepatomegaly, hyperlipemia, hypoglycemia and no increase in blood sugar after injection of epinephrine or glucagon. In Type II (Pompe's disease, cardiac glycogen storage) the main expression of the disease is cardiomegaly, and at times amyotonia. A muscle biopsy may lead to the correct diagnosis. In the types due to absence of debranching enzyme Type III (Coris disease) and to deficiency

of liver phosphorylase (Type VIa, Her's Disease), marked hepatomegaly is the principal clinical feature. The epinephrine tolerance test may show a rise in blood sugar. The type due to deficiency of muscle phosphorylase (Type VIb, Schmid and Mommaerts) has been found (to the present time) only in adults and leads to severe limitation in physical activity and excessive glycogen deposits in striated muscle.

New types of glycogen storage disease due to other enzymatic defects will undoubtedly be found if a careful search is made for them. Striking hepatomegaly, cardiomegaly, or muscular weakness in varying combinations should raise the question as to glycogenosis.

Hospitalization for a variable period should be anticipated for the carrying out of studies required. Upon completion of their study, patients will be returned to the care of their referring physicians who will receive a complete narrative summary and report of our findings.

Physicians interested in having their patients considered for admission to this study should write to:

Paul A. di Sant'Agnese, M.D.
National Institute of Arthritis and
Metabolic Diseases
National Institutes of Health
Bethesda 14, Maryland.

*Based on the classification by Stetten, DeW., Jr. and Stetten, M. J., *Glycogen Metabolism. Physiological Reviews* 40:505, 1960.

MISCONCEPTIONS CONCERNING DERMATOLOGY

Joseph Farrington, M.D., *Jacksonville, Florida*

- ***The improper use of some modern drugs in dermatological disorders may not only be expensive but can also unnecessarily prolong disease and in some cases be very hazardous***

FOR SOME YEARS, as a member of the economics committee representing the dermatologists of my state, it has been my duty to sit at many conference tables with doctors, laymen, insurance representatives, and politicians. Often, working through the various reference committees of my state medical society, endeavors have been made to arrive at reasonable and equitable fees for our services. As you know, these are now frequently handled through such agencies as the Industrial Commission, Blue Cross-Blue Shield, "Medicare," Veterans Administration, and many others. From such experiences I have found certain false ideas, misconceptions, and inaccurate information occurring again and again. As is the case with the "doctor image" in general, the unusual number of misconceptions regarding dermatology is in part due to the poor "public relations work" done by dermatologists themselves—their unwillingness or inability to inform their medical colleagues and the public of the truth concerning their specialty.

False Ideas

My remarks are not entirely selfish or based on self-interest, but any false ideas about dermatology involve a considerable block of medical practice. Dermatology accounts for ten to 15 per cent of every day medical care; 45-60 per cent of industrial or compensable disease is diseases of the skin. By the most reliable statistics, cancer involves the skin more frequently than any other organ of the body. Thus, practically all physicians are confronted with cutaneous problems which afflict their patients. Moreover, cutaneous changes properly detected and interpreted

can frequently provide the key to puzzling medical diagnostic problems. The skin is indeed a window to internal disease. It is significant, in this respect, that 13.8 per cent of the queries in the question and answer section of the *J.A.M.A.* have dermatological implications.¹

Situation More Treacherous

In the past, practitioners who knew almost nothing about dermatology ordered zinc oxide salves or other bland preparations for all undiagnosed eruptions. The situation today has become more treacherous because under similar conditions antibiotics, steroids, antihistaminics, and antimetabolites are prescribed without knowledge of the nature of the morbid process being treated nor of the numerous side effects. The deficient knowledge of physicians about cutaneous medicine has become more serious than since the introduction into dermatologic practice of new drugs and new uses for old drugs which may have remarkable efficiencies in specific disorders or under specific conditions (e.g., griseofulvin, anti-inflammatory steroids, nystatin, amphotericin B, chloroquin and its analoges, sulfones and sulfapyridine, folic acid antagonists and other cytotoxic drugs and psoralens). The indiscriminate or improper use of these drugs in dermatological disorders, however, may not only be expensive, it can unnecessarily prolong disease and in some cases be very hazardous. At present corticosteroids and griseofulvin in particular are widely misused by physicians who attempt to treat skin disorders without regard to proper diagnosis. No amount of tranquilizers, steroids, or antibiotics, for example, can eradicate scabies or a host of other parasitic infestations.

¹Presented at the 108th Annual Session of the Medical Association of Georgia, May 6, 1962, Savannah, Georgia.

In contrast to this great need in medical practice for elementary knowledge of dermatology, the curricula of many medical schools even today so neglect cutaneous medical teaching that their graduates are prepared with little more than lay conceptions about the skin. Dermatology is frequently relegated to a small obscure section under the department of medicine where a few hasty lectures and a list of prescriptions are given to over-burdened junior or senior medical students. Happily, for Georgia this is not the case. Witness the teaching skills of such men as Jack Jones, Herb Alden, the Haileys, Sam Rosen, Bill Dobes, Joe Rankin, Phil Nippert, Bazemore, and more recently Sid Olansky. Most of these men I have known for many years—men who are not only able clinicians but who have also had fruitful academic careers and given to the graduates of the medical schools of your state a good foundation of dermatologic knowledge.

Never Die; Never Cured

How many times has the dermatologist heard this statement: You are in a wonderful specialty; your patients never die and are never cured. Dermatologists would be quite happy if this were only true. In a survey at the Los Angeles County Hospital in a six year period from 1940-1946 there were 120 deaths on the dermatology service.² The saying "never die" disregards the significant number of deaths due to pemphigus, mycosis fungoides, Kaposi sarcoma, lymphoblastomas of the skin, melanomas and other skin cancers and exfoliative dermatoses. Despite these, the mortality from skin diseases is far below that in many other branches of medicine. There is no justification for the statement that the patient is "never cured." There are many diseases, even of a nondermatologic nature, against which physicians remain helpless. For example, the prognosis in the common cold, most headaches, some types of heart trouble, many cases of cancer and leukemia, and some forms of kidney diseases continue to be very poor. It is admitted, however, that due to modern bacteriology, immunology, chemotherapy, and steroid therapy great progress has been made in this century. One should not forget that these sciences are also applicable in dermatology.

The patient with heart disease, kidney disease or hypertension does not, as a rule, expect a cure when he goes to his physician and does not blame him or the profession when this is not forthcoming. However, the patient with chronic eczema of the hands or a scaly patch of psoriasis blames dermatologic ignorance when he is told that the cause of his trouble is unknown. The patient with diabetes or ulcer of the stomach is often more or less resigned to the fact that he must adhere to a strict diet and follow

a regime of treatment for the rest of his life. Not so the patient with psoriasis or some forms of eczema, chronic hives, or pruritis. Although the dermatologist lacks specific therapy for many such conditions, he does possess valuable palliative and corrective measures which, if followed, will keep most cases under control.

Less Scientific Foundation?

The belief exists among medical men, and I believe mainly through them, and also among the laity, that the treatment of diseases of the skin has less scientific foundation than that of diseases of other organs. What is meant by the remark "treatment is not scientific?" If it means that one does not understand the exact mechanism set in action by a given therapeutic agent, then the dermatologist must acknowledge that the statement is in a large measure true; but, in this event the same must apply to all the rest of medicine. The dermatologist knows neither more nor less than any other physician about the exact manner in which most of the common and effective drugs and procedures which he uses exert their action. The cardiologist who uses digitalis knows no more and no less concerning the precise way in which the conductivity and threshold for stimulation of the heart is reduced by the drug than does the dermatologist concerning the manner in which sulfur exerts its beneficial effect in seborrheic dermatitis or acne. To cite only a few more examples, the scientific basis for the use of mercurials, resorcinol and arsenical preparations in certain skin diseases is quite analogous to the scientific foundation for the use of quinine in malaria, of salicylates in headaches, fever and rheumatic fever, and of bromides and barbiturates as analgesics, sedatives, and soporifics. All are based on ancient and empiric observations. All are effective when properly used and all exert their effects by mechanisms which, despite extensive study, are still to a great extent shrouded in mystery.

Swimming Pool Granuloma

A boy consulted me because of a persistent, slowly growing granuloma on his knee. History revealed that six to eight months previously he had scraped his knee while getting out of a swimming pool resulting in an abrasion and the subsequent development of the present lesion. Biopsy showed a tuberculoid microscopic picture. Culture from the boy's knee and the swimming pool he frequented resulted in the growth and isolation of an acid fast rod identified as *Mycobacterium balnei*. The inoculation of this organism into the forearm of a volunteer faithfully and accurately produced the disease swimming pool granuloma from whence it was again cultured. A moment's reflection on your part,

I believe, will bring agreement that the time honored Koch's postulates as a basis for diagnosis have been fulfilled. Swimming pool granuloma is now occurring in northern Florida and may be confidently expected in Georgia.

In short, I can see no basis for the statement that the diagnosis and therapeutic armamentarium of the dermatologist rests on a less scientific foundation than other branches of medicine. It is sometimes said that dermatology is interested only in the minute and meticulous description of lesions and for this reason dermatology has failed to contribute its share to the progress of medicine. As pointed out by Sulzberger:³

"The skin is a large organ—indeed, the largest—with many complex structures and manifold, diverse functions (e.g., horn formation, keratohyalin, basal cells, prickle cells, pigment formers, pigment storers, oxidation and reduction systems, enzyme systems, sweat, apocrine and sebaceous glands, at least eight different kinds of hair organs, nerves, several types of special sensory end-organs, glomus organs, blood vessels of many sorts and sizes, collagen and elastic structures, thermostatic regulatory apparatus, and equipment for lipid, steroid and hormonal synthesis and for activation, storage and distribution of vitamins). This complicated, often delicate organ is exposed to many influences from within and to many forces from without. It reacts to internal and systemic influences in relationship with other organs and with the body as a whole, and, in addition, it has its own more or less independent forms of reaction to forces which affect it primarily or in independent fashion. It is only natural, therefore, that the pathologic changes caused by the varying exogenous and endogenous agencies in the highly differentiated cutaneous structures should give rise to a great number and variety of distinctive patterns of disease."

We are interested in detail minutiae of these lesions only as it enables us to interpret and diagnose diseases. For example, it is often difficult to convince the referring doctor or the patient with a few vesicles on the external ear that within a few hours to a few days he will, in all probability, have a facial paralysis or Bell's palsy resulting in a so-called Ramsey Hunt syndrome. This further illustrates that in the field of rehabilitation there is some justification in the charge that dermatology has failed to contribute its quota to the advancement of medicine. For this reason many of us have made attempts to correct this. For example, working with my ENT

and dental colleagues, we are attempting to fashion a prosthesis for these patients to make them more comfortable during their recovery period or as a correction for permanent disability.

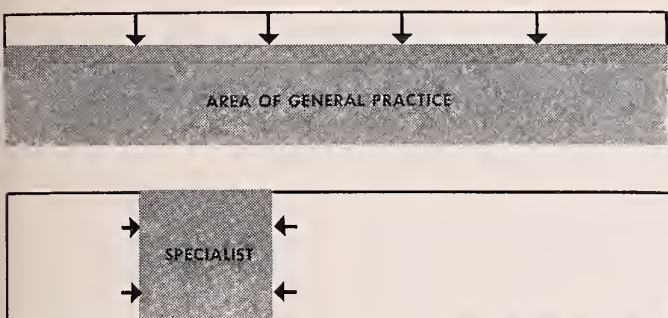
Change Within Specialty

Misconceptions may arise and persist from failure to appreciate the evolution and change within one's own specialty. When I was a medical student one had an odoriferous awareness that one was approaching the skin wards. They were crowded and cluttered with severe burn cases nearly all of which are now under the care of the surgeon. As a resident, fully one-third to one-half of our training was devoted to syphilis. With the advent of penicillin the average dermatologist sees perhaps a half dozen cases per year. The term syphilology has been dropped from our certificate of the American Board and from the name of our Academy. If these facts provoke a feeling of smugness on the part of our ENT brethren, I need only ask any one of them how many mastoid operations has he performed in the past ten years. Now the voice of the general practitioner is heard throughout the land, "I can do most of the things the specialist can do and do it just as well; therefore, my services are worth just as much as his!" To this day, then, our limitations—or, on occasion, our battle lines if you prefer—have not been clearly defined. "In the difficult cases, a specialist should be consulted." That is a familiar refrain and one that causes some general practitioners to feel looked down upon. But should it? Logic compels us to admit that it does not imply per se any basic inferiority of the general man. It is self-evident that a physician who devotes his entire time to a single field should be better able to handle difficult cases or else it is he who would be inferior. To test this principle I show you a table summarizing the results of a study concerning the treatment of industrial cases in the state of Florida for the year 1961. It was compiled in defense of a "dual fee schedule" for industrial cases—one for the specialist and one for the general practitioner.

	Total Dermatologists		Other Than Dermatologists
Avg. medical cost per case	\$170	\$160	\$174
Avg. days lost per case	79	70	81

I did not show this table to suggest or imply that all dermatoses should be referred to a dermatologist, for I firmly believe that a competent general practitioner can adequately manage 85 per cent of the illnesses of the skin. The limits of competence of a good general

practitioner can be shown diagrammatically on the "field" of medicine like this:



This illustrates the scope of general practice as well as its limitation—the upward 15 per cent representing the aforementioned difficult cases that require specialist care.

Comparing this with the scope of a specialty such as dermatology, we can see just where limitations apply the most.

Analogies are offered in defense of the proposition that the general practitioner must indeed be a superior practitioner to properly discharge his duties. Consider the general manager in business and industry; he consults specialists about his problems—engineering, accounting, legal, etc, but he calls the signals himself and draws the top pay. Should this

principle apply in medicine? The simple fact is this: every physician has limitations. Whether they are under the horizontal line or between vertical ones has nothing to do with superiority or inferiority. A man's individual ability—whether general practitioner or specialist—is the only true determinant of competence. Every physician who practices within his limitations is a *good* doctor. By that same token any physician who attempts to go beyond his proper scope is an inferior doctor.

In conclusion, to quote Jonathon Hutchinson, "The time is not far distant when diseases of the skin, instead of being esteemed as an unimportant if not repulsive specialty, will be regarded as offering unequaled opportunities for the study of morbid processes, and when they will take their proper place as introductory to the study of medicine and before trying to understand diseases which are to a large extent concealed from observation, the student will attempt first to master those which are exposed to vision." I think that time has arrived. Furthermore, all of us who are dedicated to the reach for truth are also physicians dedicated to service—service to our fellow human beings who happen to be sick and seek our aid, our techniques, our knowledge, and I hope our wisdom.

567 Florida National Bank Building

SOUTH FULTON HOSPITAL FIRST IN NATION TO GET NEW ANTI-DISEASE AIR UNIT

South Fulton Hospital will be the first hospital in the nation to install specially designed air-handling equipment to combat pathogenic bacteria, a cause of infection. The equipment, of unique flexibility and efficiency, will control air-flow, temperature and density of humidity during surgery, and will be installed in operating rooms of the new Southside hospital.

Dr. L. M. Hewitt, Chairman of the Governing Board of the hospital that is now under construction on Cleveland Avenue, East Point, reports that the Biophysics Section of the Atlanta based Communicable Disease Center will use the new facilities at South Fulton Hospital to conduct studies into the bacteriological quality of recirculated air. This will be the first study being planned in four hospitals throughout the United States. Dr. Lawrence B. Hall, Chief of the Biophysics Section, says the installation of this special equipment at South Fulton Hospital will put the Disease Center several months ahead in their schedule for research into the problems of staphylococci infection in hospitals.

"Contaminated air appears to be one of the main links between infectious sources and susceptible patients," stated Dr. Hewitt; "The new equipment designed for South Fulton will make possible continuous study of the quantity of pathogenic bacteria in the air being circulated in operating rooms during surgery. It will permit analysis of the effects of the rate of air-flow, of temperature and

of the amount of moisture in the air. In short, the system will determine the ideal conditions under which to perform surgery," he added.

The hospital's operating rooms will have air supplied through ceiling grilles and will exhaust it through baseboard grilles that extend almost the entire perimeter of the room. Fresh air entering the area will pass through high efficiency filters, through a water spray, and through more filters. Each room will be equipped with remotely controlled air volume regulators that control fans pushing air into the rooms and fans that draw the air from the rooms, thereby providing optimum air movement and pressure in each room. Temperature is adjustable and held constant by thermostats. Humidity, which has a marked effect upon air-borne bacteria, can be easily controlled.

Control of pathogenic bacteria in the air is especially important in the care of highly susceptible patients, such as newborn infants, surgical and burn patients. Data collected in the study at South Fulton Hospital will be reported each month to all hospitals throughout the United States.

Installation of this special equipment is indicative of the modern up-to-date look to be found in South Fulton's new medical facility, already labeled by some authorities as one of the nation's finest hospitals.

CORRECTION OF RECEDED CHIN COMBINED WITH RHINOPLASTY

Frank Hoffman, M.D., *Savannah*

■ *The most commonly associated defect which distorts the profile is a receded chin*

THE INCREASED POPULARITY OF RHINOPLASTY makes us more cognizant of the facial profile. One should evaluate the chin with the nose to obtain a pleasing facial profile. For example, after correcting a receded chin, one may find the correction of the nose need not be as marked as was first believed. Shortening the nose in a patient with a receded chin will emphasize the flatness of the chin in the facial profile.

This presentation is limited to a rhinoplasty combined with the correction of the undeveloped receded chin without malocclusion. In these cases, the principle of correction is to increase the projection of the chin by a transplant between the bony mandible and soft parts of the chin.

Choice of Implant

1. Fresh rib cartilage or iliac bone from the patient would be ideal. However, obtaining the graft is time consuming and postoperatively painful. Most patients object to the additional procedure.

2. Homologous costal cartilage obtained from persons fatally injured with no pathology or infection is well accepted by many surgeons. The cartilage is removed under sterile conditions and refrigerated in aqueous solution of merthiolate 1:1000 to four parts of sterile saline. It should be cultured each time before use.

3. A subdermal implant material called Silastic is now gaining popularity. It is a silicone rubber manufactured by Dow Chemical Company. Silastic offers

many advantages. It is soft, tissue inert, quickly sterilized in an autoclave, and is very easily molded on the table to fit any asymmetry and curve of the receded mandible. I have found that Silastic lends itself to easier modeling with scissors than with a knife blade. Silastic has been used successfully, but like all material, it has yet to pass the test of time.

4. Rish¹ designed and advocates linear high density polyethylene chin implants. They are produced in four sizes. The implant is inserted through a submental incision into a tight subperiosteal pocket (see Fig. 1). Its standard fixed posterior curved surface and width does not always adapt itself to various curved surfaces and asymmetries of the receded mandible.



Figure 1

Presented at the 108th Annual Session of the Medical Association of Georgia, May 6, 1962, Savannah, Georgia.

I have replaced three Rish implants because they protruded on the left side. All three of these patients stated that the new implant (bovine cartilage) felt softer and more like their own chin.

5. Bovine cartilage is preferred by Goldman.² It is prepared by Armour and Company and stored in a sterile jar which needs no refrigeration. It models easily and is readily available. The implant is cut from the cartilage's center which is curved. A part of the graft is usually absorbed over a period of years. Occasionally, the entire graft may be absorbed. The absorbed cartilage is replaced by layers of fibroadipose tissue which leaves a soft natural feeling chin (see Fig. 2, 6, and 7).

Technique

An easy, practical method of determining the amount of correction necessary is through use of pictures and sketches of the patient. The profile photograph is placed with the picture side on the X-ray box. By pencil shading the amount of nasal hump to be removed, and by sketching in the necessary amount of implant needed to correct the receded chin, one can visualize the end result.³

Methylene blue is used to outline the position of the implant on the chin. A vertical center line is marked on the chin. Palpation of the mentum helps to delineate the lateral markings. The superior and inferior lines are then drawn. A caliper is used to measure the length and width of the mapped area. The projection needed to build out the contour of the chin is measured with a centimeter rule. These measurements are then applied to the cartilaginous im-



Figure 2

plant. At the lateral periphery of the mapped area, a depression is made in the chin with a blunt lumbar puncture needle. This serves as a constant landmark for the traction sutures when inserting the graft.

A 15 Bard-Parker blade makes a scratch in the horizontal fold under the chin which is approximately 1-1.5 cms. from the edge of the mandible (see Fig. 3a). A local anesthetic augmented with epinephrine is injected.

Now the bovine cartilage is modeled with the previous measurements as a guide. Eight to ten perforations are made through the graft with a 15 needle.



Figure 3—Preoperative



Figure 3—Postoperative

This allows soft tissues to grow through and fix the graft. If one needs more curve in the graft, three parallel V-shaped grooves are placed on the back of the graft (see Fig. 3b).

An incision approximately two cm. long is made through the previous submental scratch mark down to the lower border of the mandible. Any bleeders are tied. The periosteum is incised. A sharp Joseph periosteal elevator is used to raise the periosteum. Thus, a subperiosteal pocket with its overlying fat is made to conform to the methylene blue outline (see Fig. 3c).

A black silk pilot suture is inserted on each side of the graft. The needle is inserted in the subperiosteal pocket to emerge through the previously made skin indentation with the spinal needle. The graft is properly positioned while traction is maintained on the silk sutures. Several 3-0 catgut sutures are placed from the periosteum above through the available tissue below. The skin is closed with 4-0 silk (see Fig. 3d and 3e).

The rhinoplasty is now corrected. Although most authors recommend the rhinoplasty be done first, there are several good reasons for doing the rhinoplasty last.

1. By doing the rhinoplasty last, one can immediately tape up the nose at its completion. This prevents considerable swelling of the nasal soft tissues,

especially if one should encounter some oozing towards the end of the surgery.

2. When using the submental chin incision to insert the implant, one works in a sterile field. Doing the chin first avoids changing gloves and instruments which should be done in going from the nose to the chin.

After taping the nose, one-half inch adhesive is placed on the chin above and below the graft. A vaseline gauze strip is placed over the sutures. An elastoplast strip is strapped over the adhesive in order to form a tight fitting dressing.

The dressing and sutures are removed on the fourth postoperative day. A dry sterile dressing is placed over the suture line together with half inch adhesive above and below the graft for two additional days. The diet for the first day is liquids. For the next five days, the patient is kept on a liquid-soft diet to avoid chewing. Junior baby food is well accepted.

The chin implant can also be inserted through a buccal incision. This approach avoids a slight submental scar. Millard⁴ reported a series of 40 chin implants placed through a buccal incision without any significant infection.

Summary

The planning of a rhinoplasty should include correction of a receded chin when present, in order to

Fig. 3a. Submental incision is made down to Fig. 3b. Modeled cartilage being perforated with a 15 blade.

Fig. 3c. A Joseph periosteal elevator and curved scissors are used to raise the periosteum.

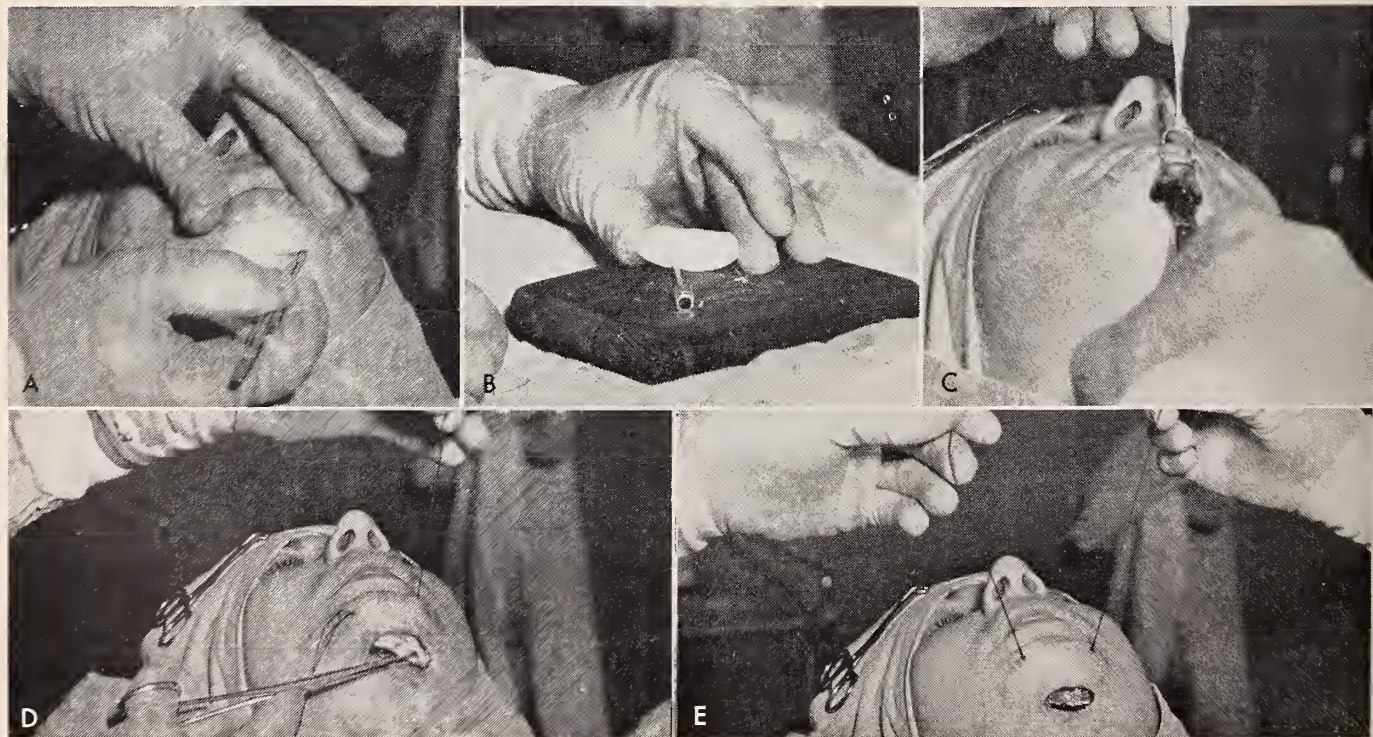


Fig. 3d and 3e. The graft is inserted in the subperiosteal pocket with the aid of pilot traction sutures.



Figure 4



Figure 6



Figure 5



Figure 7

obtain a pleasing profile. A chin transplant is simple and rapidly performed. Correction of the chin should be combined with the rhinoplasty as one operative procedure whenever feasible.

24 Medical Arts Building

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APPLICATION OF PSYCHIATRY IN GENERAL PRACTICE

I. H. MacKinnon, M.D., *Milledgeville*

- ***Neurotic symptoms where no physical basis can be found should be looked upon as serving some purpose to the patient.***

THE PRINCIPLE UPON WHICH MODERN PSYCHIATRY is based dates back to the earliest days of medicine and is not of recent origin as assumed by many. It may have taken on, however, a new appearance, increased popularity and developed some additional views and formulations which may have been responsible for these opinions.

The general practitioner of previous years was fully aware of the functional disturbances in his patients, and resorted to the use of placebos, suggestive and persuasive techniques that seemed to work satisfactorily for that particular era. He also maintained a closer relationship to the family as a counselor and his patients readily presented their personal conflicts for explanation and solution.

During the last half century progress in medicine and changes in emphasis have resulted in the development of specialization with scientific advances centering its attention on the biological and organic aspects of disease. This has had a tendency to direct the physician's attentions toward individual organs rather than a person with organs.

Assistance Not Available

Patients with nervous disorders of a functional nature have increased in numbers and the needs for psychiatric assistance are not available. Psychotherapy has been one of these specialties that has flourished in this modern age where functional disorders demand medical care and attention. Most of these problems can be taken care of efficiently by the general practitioner, as there will never be enough psychiatrists to handle only a limited number of cases where the condition is too complicated for the usual physician.

There is a great deal of re-education of the public required in changing views and eliminating the stigma associated with nervous and mental disease. The attitudes of the people in general infer that nervous troubles are something you can't talk about for fear you might be rejected and unaccepted by your circle of friends. It is considered a sign of weakness and no one wants to be considered in such a manner by the outside world or by personal reflection. The individual having to live with himself has to protect his ego from depreciation and if some physical explanation can be found it is more consoling and reassuring. People in general will not accept and will deny any possibilities of a psychiatric problem in themselves. It is all right for the other fellow to be involved but not themselves. This precious narcissistic self could not think of any such possibility.

This is the reason people will try every other kind of professional approach first and as one last act of desperation reluctantly see the psychiatrist. This is usually after everything else has failed and their condition is so advanced that the psychiatrist does not have the advantages offered by earlier illnesses and cooperative patients.

Psychiatry today is suggesting that the general practitioner endeavor to maintain the nervous and mental patient in his home environment and when additional care is needed that he be referred to the local psychiatric clinic. If hospitalization is necessary, this should be initiated in the local general hospital where a few psychiatric beds should be reserved for this purpose. Contact with his patient should be retained by participation in the therapy program which assures the awareness of the nature of the problem, and therapy required so that when the

patient returns home he may be properly followed by his family physician.

It is important for the patient to be near his family and to be treated in the hospital like any other medical illness. It is also reassuring to the family to visit and be close to the family physician in whom they have confidence and trust.

It is surprising that many of these cases with the aid of some tranquilizing drugs or electric shock treatment will become readjusted quickly and in a few days can return home. A short stay in the hospital is to be recommended, as long confinement delays and prolongs recovery. This same attitude is applicable to patients who are confined in state psychiatric hospitals and early consideration should be given to this policy as soon as the patient's condition is suitable. Closer relationship of the patient's family physician should be maintained with the state hospital so that complete furnishing of reports of the patient's condition and information relative to treatment required upon returning home would prevent the speedy return of the patient to the hospital.

Programs Provided

Educational programs consisting of didactic psychiatric presentations, case conferences, and seminars could be provided for those physicians who were desirous of being informed about modern diagnostic and therapeutic methods. Illustrative material could demonstrate the detection of early signs of psychiatric problems and the various factors on situations, internal or external, that could be etiological. Emphasis could be placed on the selection of proper drugs for specific conditions as well as when to call or use the services of psychiatric consultants.

A review of the statistics of the number of functional or emotional determined disorders consulting the general practitioner is modestly estimated at over 50 per cent. These patients are just as ill and have symptoms which are just as disturbing as with the physically sick person. To be told that it is their imagination or there is nothing wrong does not relieve or satisfy the patient. These approaches drive the patient to the chiropractors and to other similar groups. Success in the handling of these cases requires that the physician have a better understanding as well as a healthy psychiatric attitude toward the functional patient if he is going to be retained in the field of ethical medicine.

Comparable Standards

The same standards and theories applicable to the field of medicine should apply to psychiatry. They apparently do, but factual scientific evidence is difficult to apply in this area. The mind cannot be

seen under the microscope, as it is abstract and intangible. However, the mind is just as concrete and organized as any other organ in the body and demonstrates some of its operation through emotional expression in the somatic aspects of the body.

Conflict Within System

The symptoms of nervous disorder represent a disturbance or conflict within the psychological system, and this imbalance is reflected into various parts of the body. Likewise, physical disease may produce secondary reflections into the central nervous system causing nervous and mental symptoms of an organic nature. There is also a superimposed reaction or disturbance in the psychological system which is purely functional when the individual becomes concerned or perturbed about an existing physical condition. This usually requires a considerable amount of explanation and reassurance to re-establish peace and security in the person's mind.

Nervous patients have many factors in their personalities that predispose them to psychiatric conditions. There is usually a precipitating situation that is responsible for the release of the illness as well as one or more contributory factors that can complicate the disturbance. Perpetuating factors may play a role in maintaining the illness and must always be considered when responses are not obtained or the condition is being prolonged. What has just been mentioned are exactly the same phenomena that are considered by the physician in physical medicine and was presented to illustrate that psychiatry has an identical approach.

Evidence Not Always Productive

The obtaining of evidence through history taking is not always productive as patients may be unaware of the nature of their stresses or at least have forgotten or regressed some disturbing experience. There are others who are fully cognizant of emotional situations when they are questioned but have not attributed them to symptomatology presented and could not see any relationship. The stressful situation may be internal, within the psychological organization, or may be a reaction to some external problem. The frustration may be a minor one that would not be looked upon as particularly important, but may be highly individualistic and represent some specific focus common to this person. The degree and extent of the reaction may be all out of proportion to the nature of the conflict. Also the capacity of the individuals to quickly restore themselves when upset may be greatly prolonged, and the reaction is maintained long after provoking stimulus is no longer present. In other words, the situation that caused a

feeling of depression is past, doesn't exist, is no longer in the picture but the patient continues to have symptoms that were appropriate for the moment but continued on indefinitely when no longer justifiable.

The capacity for self restoration is an inherent function of the human individual with physical, nervous, or mental disease. The successful doctor knows where to let well enough alone and allow one's own natural defense processes to come to the rescue of the individual. The psychological protective apparatus will wall off and focalize the destructive disturbance and resolve the psycho-inflammatory process. The psychiatrist, like the physician, supports human nature with additional protection when the system becomes overwhelmed with the unhealthy disturbances, as one would give an antibiotic when an infection gets out of hand. The stress is lessened to where the patient's forces can take over and maintain its own healthy operation.

No Age Immune

Frequently this is accomplished rather easily just by getting under the physician's care, being assured through the discussion of existing problems, being relieved of anxiety by explanations of an authority figure, rest and relaxation by medication, and replacing doubt with confidence and faith. However, there are all degrees of reaction and more intensive therapy may be required in the more serious disorders. There is no age that is immune from psychiatric afflictions which covers childhood to senescence. There are periods, however, that produce a greater percentage of problems which may be found at the age when children start school, at puberty, when entering college, starting in the vocational field, making decisions relative to marriage, during and after childbirth, during the menopause and finally in the geriatric period of life.

Parental Involvement

In the childhood area, not only is the child susceptible to various situations that may be disturbing, but the parents as well are secondarily involved in the child's reaction. A few of these may be mentioned, namely the defective child who may not only interfere with other growing children but may be upsetting to the parents as well. The same situation may occur with the chronically sick child and to reactions from operations and continued periods of hospitalization. Mention should be made also of the child's non-acceptance of a new addition to the family

and the uprooting of children by moving to new neighborhoods as well as the loss of a parent by death, divorce, or separation. Situations should be looked for that produce fear, anxiety, anger, hostility, resentment, and depression. Likewise, disappointments, disillusionments, rejections, or situations resulting in failure can be responsible for the release of childhood problems.

Conflict Within Individual

Emotional reactions in all ages of life are due to some conflict within the individual and to arrive at the factors responsible requires an investigation into all phases of his daily life, his home, his children, his love life, his occupation and social life, to find the determining causes.

Of course, life is filled with frustrating situations and somehow or other people throw off their problems and somehow manage to survive. There are others with more sensitive nervous systems who are affected more readily and require additional help and assistance in their daily struggles. It might also be stressed here that there are personalities that have a knack for getting into or being involved in frustrating situations. This group is most experienced and are champions at finding troubles to react to and becoming involved in. These cases are just as challenging to alter and modify by the psychiatrist as by the regular physician.

Recognition and Realization

The physician must be prepared to recognize all the possibilities that are interfering with normal health and realize the importance he plays as a counselor and an advisor that satisfactorily answers the families' questions rather than ignoring or passing off lightly matters that may be very serious to future adjustment of the family constellation. One can't help but mention a few illustrations in this direction. For example, such matters as sexual indiscretions, handling the psychotic or aged members of the family who need hospitalization, recognizing the depressed patient who may be suicidal with adequate warning to the family and protection of the individual.

This is a broad subject and it is only possible to cover some of the areas in which the medical man may be of service to his patient and assist with intelligent participation in the solution of many of the problems that are crucial to the family and place them under great stress and insecurity. Care should be exercised with patients who force decisions from the physician on personal problems. These are usually matters that they are unable to carry out but

would like to, and they use the physician's authority for the initiation of same. The physician will never hear from the patient unless he is severely blamed for recommending or suggesting certain actions. This specifically refers to recommending separation, divorce, or approving indiscretions or extra-marital affairs or other matters of this nature.

A few remarks should be made about the precipitations of physical disease by some emotional crises. The susceptibility of some patients to various disease entities may be related to the chronic tensions that lower the resistance of the individual's tissues so that he becomes an easy victim to various somatic conditions. The old saying that a healthy mind makes a healthy body of course also works in reverse. There should be no dichotomy when dealing with a total individual. He is not just a heart, lung or liver, but a body, with a person living in it reacting emotionally with attitudes and feelings which may play an important role in his illness. Security and adaptations within the patient's external and internal world contribute an important part to the total balance and homeostasis of the mind and body, namely physical and mental health.

Neurotic symptoms where no physical basis can be found should be looked upon as serving some purpose to the patient. Although there may be innumerable situations that produce these neurotic reactions, they usually represent either a conflict within the patient's psychic apparatus or frustrations or situations outside that the individual cannot face, handle, or control. It may be difficult to find out for what reason the patient is using his illness, as he may not be consciously aware which is utilized to avoid the development of self criticism and guilt. Many of these problems may be within the family constellation and in vocational or sociological situations. Patients frequently use their illness to get sympathy and attention, but they also may use it to dominate as well as to annoy and irritate those in their immediate surroundings.

Self-Care

The acute situations may take care of or resolve themselves but occasionally may need medical care for a short period of time. It is the chronic hypochondriac with a history of neurotic symptoms that is a challenge to the psychiatrist to promote a successful result. The majority of these people don't want to get well even though they give lip service to the contrary. The neurosis is resistantly stronger than the forces for alteration.

Energy has no consideration for the nature of its expression. It will go in the direction of least resistance and when the individual has formulated neu-

rotic or somatic patterns they become fixed and conditioned in these selected areas. This pattern, once formulated, has such strength that even the will of the patient and doctor may have difficulty in redirecting the energy into positive, satisfying, pleasurable, and peaceful expression. It also means that there has to be something put in the place of the neurosis and this may mean the developing and training of functions which have shrunk from disuse and are helpless in modifying and changing the unhealthy organization.

Superficial Approach

Individuals of lower intelligence and poor education respond more readily to the superficial approaches of suggestion, persuasion, and various drug therapies. Even though some cultural and educational backgrounds are necessary for the more intensive psychotherapies, it may take a much longer period of time to modify the patient's symptoms. The more involved the ideational aspect of the individual, the more complicated the mental content, while in the uneducated the problems center more in primitive physical or somatic expression.

The individual may also be using a neurosis for secondary gain, namely to obtain disability payments, compensation, to be excused from working, to obtain unemployment pay, or welfare funds. This kind of assistance was designed to help people over economic periods of distress but in some types of personalities it may destroy the work habits and develop a dependency and invalidism that remains indefinitely to pauperize the individual.

Menopause Release of Symptoms

The menopause is a period of life when we frequently find a release of neurotic symptoms. Individuals are usually aware of the physiological changes that are taking place and know that family and society in general make allowances for persons during this stressful stage. However, many patients take advantage of this situation by letting down and not accepting responsibilities for which they will not be blamed and have justifications for their own conscience. There are many questions at this time that can be answered by the physician which will be reassuring and consoling to the patient. There are numerous fears found to be present related to the possibilities of the existence of cancer and undue dreads of developing a nervous breakdown. They also have additional thoughts that their sexual desires will disappear and changes will occur that will make them unattractive physically with the possibilities that their husbands may lose interest in them. It is also noted that resentment may be brought out

toward the male for his continued productive abilities. Also, a neurosis or a depression may be released at the menopause that has been lurking in the background and is brought to the surface when the normal defenses become weakened. References might also be made to the male at this age in life whose neurotic symptoms can be used to justify certain inadequacies and to relieve him of responsibilities that he may have been struggling with for an indefinite period.

Constructive and Creative Outlets

Mention can also be made of the cardiac, the pensioner, or retired worker whose energies need to be diverted and channeled into new constructive and creative outlets. Neurotic and depressive reactions are not uncommon and early death from intercurrent disease is well known. The plans and preparations for retirement are difficult when idleness, loneliness, and opportunities for expression of energies are not available. Education and rehabilitation of these people is one of our most important projects and most challenging to the general medical man.

Two Extremes

There are two extremes of people who seem to have difficulty in adjusting to the realities of life. The first is the dependent, passive personality who accomplishes little on his own and needs a catalyst to make his system function. Some other person who can influence, lead and stimulate the individual to activity may be a brother, sister, symbol or a father, mother type of surrogate. These people on their own are helpless, like a ship without a rudder, but will function well in a parasitic type of attachment. The other type is the one who is more aggressive and battles authority figures. They frequently are individualistic, do not accept conventions and customs and show little respect for parental symbols and have a preference for the unusual, unique, or different things not related to precedence. These people who defy authority are usually the ones who need it the most. The development of a disciplinary and controlling system within the individual starts in childhood and is reinforced at various phases of growth and development resulting in the mature adult person who can get along with himself and the world. The early attitudes toward authority, as well as the kind of authority training within the family in the social, economic and governmental environment determines the methods of identification or imitative patterns that can be expected in future

behavior patterns. The individual who has avoided and straight armed authority does not incorporate a healthy disciplinary pattern and continues to react in an exaggerated form in this area of life when society and the world of reality is met, namely during the adolescent period. A certain independence and individuality is expected but non-conformity without an adequate controlling system in the individual, especially in the kind of society we have today, plays an important role in adolescent problems, delinquency, and antisocial behavior. This is a problem for the physician to understand and recognize early in the developmental period of life for proper advice to the family, namely mental hygiene. Prevention, like any other field of medicine, is the answer to meeting existing problems in psychiatry. The family physician will play an important part in contributing to this kind of prophylaxis in the development of a strong mental system as well as a physical machine.

Disease may be depicted as an imbalance in functioning structure. Homeostasis and equilibrium are not only required in our physical patterns but also in our spiritual, philosophical, emotional, and intellectual systems. Likewise, balance in our social, economic, political and governmental world is conducive to balance within. An upset in any of these systems can cause degrees of disturbances in most all people and more so if other aspects of the person are poorly integrated. It is also possible that poorly balanced people can provide poor leadership, causing a disturbed society eventuating in collapse of any or all of our social and economic systems. A piece of cloth is only as good as the strength of the individual threads and the character of the weaving, which determines its capacities to withstand the stresses and strains of its exposures.

System of Beliefs

A human individual to be healthy requires a system of beliefs, not only in his own systems, but also in the outside world, which he needs and accepts to cooperate as a balanced individual. Faith is the strongest binder which holds together all the functioning abilities of the individual. It is like the mortar that holds the individual bricks together in a solid structure. We do not know where the functions of faith are localized in our central nervous system nor do we know its physiological projections. The chemistry of faith certainly is different from that of hopelessness or despair, as its intense and continual reflections can mean the difference between health and functional disease. When hope, courage, and confidence wanes—fear, anxiety, anger

and all negative emotions take over. These traits cause tensions and projected catabolic disturbances, and alterations in capillary balance and cellular functions. Organ localizations and tissue selectivity will depend upon predilections determined by heredity, constitution, and experiential physical and psychological conditioning.

Strong faith can hold together systems that are immature and inadequate and one frequently is amazed how these individuals can function with such dependent, overprotected, naive, and unworldly defenses. Many of our so-called cures are related to transference and faith developing or reinforcing procedures where symptomatology is of a functional nature. The physician who understands the operation of faith in close proximity to his scientific medical background becomes a great healer when he can humbly, modestly, and honestly understand the appli-

cations of the powerful influence that is available in his omnipotent profession.

Milledgeville State Hospital

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GEORGIA HEART ASSOCIATION ANNOUNCES NEW OFFICERS

Dr. William B. Fackler, Jr., LaGrange internist, has been named President of the Georgia Heart Association.

The new President took office at the Association's 14th Annual Meeting at Jekyll Island, September 8, 1962. He succeeds Dr. Clarence C. Butler of Columbus as head of the voluntary health agency which is devoted to the fight against diseases of the heart and blood vessels.

Named President-Elect was Dr. J. Willis Hurst, Professor and Chairman of the Department of Medicine at Emory University.

Dr. Fackler has served as Secretary and as Vice President of the Association and has been a member of its Board of Directors since 1956. He has served as Chief of the LaGrange Heart Clinic for indigent patients; as a member of the Association's Committees on Clinics, Professional Education, and Membership; as Chairman of its Budget Committee; and as a Delegate to the Assembly of the American Heart Association.

Dr. Hurst has also served as Secretary, as Vice President, and as a member of its Board of Directors. He has served as a member of the Research, Budget, and Clinics Committees, and Chairman of the Association's Committee on Professional Education. Dr. Hurst has also served as a Delegate to the Assembly of the American Heart Association and a member of the national organization's Committee on Rehabilitation.

Mr. Carter L. Redd of Atlanta was re-elected Chairman of the Association's Board of Directors.

Other officers elected were Dr. John L. Elliott, Savannah, and Rease Inge, Atlanta, Vice Presidents; Dr. Henry S. Jennings, Gainesville, Secretary; and Herman Jones, Jr., Atlanta, Treasurer.

Named to the Board were Dr. Linton H. Bishop, Jr.; Brunswick A. Bagdon; Jack Isenberg; Richard H. Horsey, all of Atlanta; Charles S. Wagner, Marietta; Dr. Thomas D. Johnson, Albany; A. S. Albright, Thomasville; Dr. Lawrence Lee and Edmund Ewing, Jr., Savan-

nah; Dr. W. G. Elliott, Cuthbert; Dr. Addison W. Simpson, Jr., Washington; Dr. Frank Wilson, Leslie; and Mrs. Virginia Bagwell, Monroe.

Elected Delegates to the Assembly of the American Heart Association from Georgia were Dr. Fackler, Dr. Haywood N. Hull, Atlanta; and David P. Mason, Tift College in Forsyth, Georgia. Alternate Delegates include Dr. Dan Burge, Atlanta; Dr. John L. Elliott, Savannah; Dr. Curtis G. Hames, Claxton; Dr. Hurst, Dr. Jennings, and Mr. Louis F. Gordon, Jr., Atlanta.

Dedicated service in the fight against heart and blood vessel diseases on local, state and national levels won Georgia Heart Association awards for four of its distinguished members.

They are Dr. Clarence C. Butler, Columbus, retiring President of the Association, who was honored for his leadership during the most successful year in the history of the Heart Association; Dr. Joseph C. Massee, Atlanta, recipient of the "Heart Of The Year" award, for outstanding service to the Association for more than a decade; to Lewis F. Gordon, Jr., Atlanta and W. Cameron Mitchell, Hampton, 1962 Heart Fund Co-Chairmen, in appreciation for their efforts and those of the other local volunteers which resulted in a substantial increase in public support of the Heart Fund and program activities.

The election and installation of officers and directors ended the two-day meeting of the Georgia Heart Association, which was highlighted by the 14th Annual Scientific and Volunteer Leadership Sessions.

Physicians attending the two-day Scientific Sessions heard four leading authorities in the cardiovascular field discuss recent advances in diagnosis, treatment, and management of heart patients.

The session for volunteer leaders included a discussion in depth of the Georgia Heart Program of research, education, and community service activities.

CLINICAL EVALUATION OF IPODATE: A NEW ORAL CHOLECYSTOGRAPHIC MEDIUM

Herbert M. Olnick, M.D., *Macon*

■ ***This new material was better tolerated by patients
than any other media tested***

ADDED TO THE IMPROVING ARMAMENTARIUM of radiologic biliary contrast media are two new products: the sodium and calcium salts of ipodate, a triply iodinated propionic acid, known in the European literature as Biloptin and Solu-Biloptin. My favorable experience with these materials comprises this report.

Ipodate is supplied as the calcium salt providing 61.7 per cent iodine, and as the sodium salt of the same acid,* providing 61.4 per cent iodine.⁵ Following oral administration, both salts are rapidly absorbed from the gastrointestinal tract and excreted by the liver into the bile in sufficiently high concentration to visualize the gallbladder; often opacification of the biliary ducts is also achieved.^{2,4,6-10} Preliminary reports indicate that the calcium salt, which is absorbed more readily than the sodium salt, appears in the biliary ducts as early as 30 minutes after administration,^{6,7} although optimal opacification of the ducts is usually attained from one to three hours after ingestion of the medium.^{4,6,7,9,10} Opacification of the gallbladder with the new medium is usually optimal approximately ten hours after ingestion of either salt,¹¹ but adequate filling for diagnosis often occurs within five hours after ingestion,^{2,4,6,7} especially of the calcium salt.^{6,7}

Method

Ipodate** was administered for routine chole-

Product referred to: ipodate (Oragrafin™).

**Also identified as 3 — (dimethylaminomethylenamino) — 2, 4, 6—tri-iodophenylpropionic acid.*

***Supplied as Oragrafin by the Squibb Institute for Medical Research, New Brunswick, New Jersey.*

cystography and/or cholangiography to a total of 90 consecutive patients who were referred for study by their physicians. Among these there were 66 women and 24 men between the ages of 16 and 72 years. Eighteen of the 90 patients had been examined previously with other cholecystographic media at periods varying from one day to 15 years before the present examination. Three of the patients had undergone cholecystectomy. Histories taken in every case prior to examination revealed no known sensitivity to previously administered intravenous media. One patient reported diarrhea of one month's duration; another reported an episode of jaundice 17 years before, while a third patient appeared to be slightly jaundiced at the time of his initial visit. Body weights recorded during routine physical examinations prior to cholecystography ranged from 95 to 240 pounds for the women and from 112 to 230 pounds for the men in the series.

Capsule and Granule

Ipodate was given as the capsule preparation, each capsule containing 500 mg. of ipodate sodium, to every patient in the series. Twenty-one of the 90 patients scheduled for study received, in addition, a subsequent dose of ipodate as the granule preparation, each packet of eight gms. of powder containing three gms. of ipodate calcium. Preparation of the patient and administration of the medium followed a uniform pattern for the entire series. The full dose of capsules was given usually as a single dose approximately two hours after a light, fat-free supper on the evening before examination. To the patients re-

TABLE I — QUALITY OF CONTRAST IN CHOLECYSTOGRAMS WITH IPODATE

Form of Medium Administered	No. of Patients	Opacification of Gallbladder					No. Showing Side Effects	
		Excellent	Good	Fair	Poor	None Cholecystectomized		
Sodium Salt (capsules)	69	37	18	5	1	7	1	7
Sodium Salt (capsules) followed by Calcium Salt (powder)	21	6	9	2	1	1	2	8
	90	43	27	7	2	8	3	15

ceiving the additional dose, the powder was given mixed in a cupful of water the next morning one or two hours before the films were to be taken. Food and fluids were restricted in every case for approximately 12 hours before filming. Doses of the sodium salt varied from six to 12 capsules in the individual case, though the usual dose was six capsules, or three gms. of the ipodate sodium. The dose of the calcium salt in every instance where it was given was one packet of powder, or three gms. of ipodate calcium. Films were exposed in the usual manner with the patient in standard positions for gallbladder and duct studies, as well as upright compression spot films.

Results

The quality of cholecystograms obtained with ipodate in this series of patients is shown in Table I. There was some degree of delineation of the gallbladder in the films from 79 of the 90 patients examined with the new medium, and the cholecystograms were rated as "good" or "excellent" in 70 of the 79 studies. No visualization of the gallbladder was achieved in eight cases and in three instances the patients had had their gallbladders surgically removed prior to examination.

Not shown in the table is the visualization of the biliary ducts obtained with ipodate. The ducts were visible to some degree in a total of 32 of the 90 studies, though in five cases only the cystic duct was visualized and in three other studies only the common duct was visible. The opacification of the biliary ducts was "good" in five of the 32 studies in which opacification occurred; in the remaining films the contrast was neither sharp nor dense enough to be diagnostic. Other authors,⁵ however, using larger doses of the calcium salt, claim up to 25 per cent good oral cholangiograms.

Reactions were relatively few and mild. Of the 90 patients examined, 75 experienced no reactions whatsoever. The most common complaint was nausea, which was reported by a total of ten of the patients studied. Other reactions, as shown in Table II, included vomiting in two cases as well as diarrhea, lower colon pain, insomnia, headache with tachycardia, and urticaria, each in a single patient. Treat-

ment was required in only one case—diphenhydramine was administered to the patient who developed urticaria—but in no case was it necessary to postpone or stop the study of the patient because of reactions. Of the 15 patients who reported adverse effects, eight had received both capsules and powder, while seven had received only the capsule preparation of the new medium (See Table I).

Nineteen of the 90 patients still had medium in the intestines or stomach when the films were taken but in only four instances did the residue appear to be significant in amount. In three of these cases, opacification of the gallbladder was good, fair, and poor respectively, and there was no visualization of the gallbladder in the fourth patient.

Summary

Ipodate (Oragrafin™) has been administered to 90 patients for routine cholecystography and/or cholangiography. The capsule preparation containing the sodium salt was administered as a single dose of from six to 12 capsules to each patient in the series. Twenty-one of the 90 patients received, in addition, a subsequent dose of three gm. of the ipodate calcium powder. Some degree of visualization of the gallbladder was seen in 79 of the 90 studies (88%) and the cholecystograms were of "good" or "excellent" quality in 70 of the 90 studies (80%). Though the ducts were visible in 32 studies, the cholangiograms were rated as "good" in only five cases.

Seventy-five of the 90 patients experienced no reactions to the medium. Ten patients complained of nausea, two developing emesis, while single patients

TABLE II — REACTIONS OBSERVED IN CHOLECYSTOGRAPHY WITH IPODATE

Reactions	No. of Patients*
None	75
Nausea	10
Vomiting	2
Rash	1
Insomnia	1
Headache and tachycardia**	1
Lower colon pain	1
Diarrhea	1

*More than one reaction was observed in some patients.

**Patient has complained of these symptoms on other previous occasions.

reported one of the following: diarrhea, lower colon pain, insomnia, headache with tachycardia, and urticaria. Diphenhydramine was administered to the patient with urticaria but treatment was not required in any others developing reactions.

Ipodate is a useful cholecystographic medium. In our experience the new medium was better tolerated than other media, and it provided delineation of the gallbladder at least equal to that obtained with other oral media. In addition, even in a single dose, ipodate will provide occasional diagnostic visualization of the biliary ducts.

724 Hemlock St.

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DEPARTMENT OF MEDICINE EXPANDS AT TALMADGE MEMORIAL HOSPITAL

Readers who refer patients to the Talmadge Hospital may find it helpful to have definite information concerning the personnel of the Department of Medicine. When the Hospital opened in 1956 the fulltime staff, in addition to Dr. V. P. Sydenstricker and Dr. Thomas Findley, consisted of Dr. Curtis H. Carter (Chest Disease), Dr. Claude-Starr Wright (Hematology), Dr. A. Calhoun Witham (Cardiology), Dr. Victor A. Moore (Gastroenterology) and Dr. B. Shannon Gallaher, who subsequently entered private practice.

Since then, the following key positions have been filled:

Dr. J. Edwin Wood, III came from Boston University College of Medicine and the Massachusetts Memorial Hospital to head up the Georgia Heart Association Laboratory for Cardiovascular Research. He is a graduate of Davidson College and the Harvard Medical School. He has made important contributions to the genetics of essential hypertension and to the physiology of the peripheral circulation.

Dr. Enon C. Hopkins, a graduate of Emory University and the Medical College of Georgia, is Director of the Division of Rheumatology and is also Director of the Student Health Service. His chief interests are in diseases of the skin, joints, and connective tissues.

Dr. Wayne V. Greenberg is head of the Division of Metabolic Diseases and Director of the Clinical Investigation Unit. He is a graduate of the University of Pittsburgh and the University of Buffalo School of Medicine. His training in endocrinology was obtained at the University of Pittsburgh, and the Sloan-Kettering Institute in New York City. He is particularly interested in diabetes and in thyroid metabolism.

Dr. James B. Hudson came to us from the Massachusetts Memorial Hospital where he received a sound training in renal diseases under Dr. Arthur S. Relman.

For a time he was Assistant Dean at Boston University School of Medicine. Here he is head of our Renal Laboratory which, of course, includes the artificial kidney.

Dr. Robert D. Lange recently joined the Division of Hematology. He is a graduate of MacAlester College and of the Washington University School of Medicine. For two years he was associated with the Atomic Bomb Casualty Commission in Nagasaki and Hiroshima and with the Walter Reed Army Institute of Research. He came to us from the VA Hospital in St. Louis where he was Chief of Hematology Research and Assistant Professor of Medicine at Washington University School of Medicine. He is well known for his work on erythropoietin.

Dr. James T. Hamlin, III recently assumed his duties as Director of the Hemodynamic Research Unit. He graduated from the Virginia Military Institute and the University of Virginia Medical School. After a medical internship at the Peter Bent Brigham Hospital he did research at the Harvard Medical School, the New York Medical College and the Rockefeller Institute. His particular interest is lipid metabolism.

Dr. Geoffrey E. King has been a member of the Division of Cardiology since 1959. He is a graduate of the University of London and came to us from the University of Bristol. He is a skilled electrocardiographer and clinical physiologist.

On January 1, 1963, Dr. Arthur C. White of the University of Louisville will come to head up a Division of Infectious Diseases. He received his training at Vanderbilt and has been at the University of Louisville since 1958. He is a Markle Scholar whose recent interests have been in the field of drug-resistant staphylococci.

Dr. Ernest E. Pund, Jr., a graduate of Emory Uni-

versity and the Medical College of Georgia, has just returned as a member of the Division of Cardiology after training at Barnes' Hospital and the University of Colorado Medical Center followed by a stretch in the U. S. Navy.

Dr. Bennett F. Horton has accepted a research fellowship in Hematology after finishing his residency training here.

Dr. Walter A. Brown has joined Dr. Wood's Division. He's a graduate of the Medical College of Georgia and also has a Master's Degree in Physiology from here so is well qualified to work in the field of peripheral circulation.

William S. Harms, Ph.D., has been with us since 1955. He is head of the Division of Clinical Chemistry in this Department, and also is Assistant Professor of Biochemistry. He has worked in experimental renal disease as it affects lipoprotein metabolism.

Edward Gardner, Ph.D. came from Ohio State with Dr. Claude-Starr Wright as research chemist to the Division of Hematology. He also holds an appointment as Assistant Professor of Microbiology. He has worked extensively on the immunologic aspects of hematologic problems.

Dr. Robert S. Botnick has recently joined the part-time faculty. He graduated from Baylor University School of Medicine and has just completed his residency training at the Hahnemann Hospital, Philadelphia, Pennsylvania. He supervises the Medical Clinic and Domicillary Medicine at the University Hospital.

We are also proud to announce the following additions to the Department of Medicine at the Veterans

Administration Hospital where, I am glad to say, Dr. Sydenstricker is extremely active.

Dr. John J. Martin, Chief of Medicine, came recently from the VA Hospital in Houston, Texas. He is a graduate of Princeton University and Harvard Medical School. He interned at the Peter Bent Brigham Hospital and did his residency at Western Reserve. His chief interest is gastroenterology.

Dr. M. Elizabeth Morgan, a graduate of this institution is in charge of the chest service at the VA Hospital.

Dr. William F. Zehl came to us in 1960 after being engaged in private practice in Connecticut. He graduated from the University of Connecticut and Temple University School of Medicine, and did his residency at Newington and West Haven (Conn.) VA Hospital and is chiefly interested in metabolic problems.

Dr. George R. Mayfield, a graduate of the Medical College of Georgia, came recently from the VA Hospital in Nashville, Tennessee. He received his residency training at the University Hospital, Augusta, and Charity Hospital in New Orleans. He is a cardiologist.

Dr. William F. Heslin has just finished an extended experience in the U. S. Army Medical Corps as Chief of Medicine at Fort Gordon, Georgia. He is a graduate of Glasgow University and received his residency training at Glasgow and New Rochelle Hospital in New Rochelle, New York.

Thomas Findley, M.D.
Professor and Chairman
Dept. of Medicine
Medical College of Georgia

GEORGIA DEPARTMENT OF PUBLIC HEALTH ANNOUNCES NEW SPECIAL SEROLOGIC TESTING FOR SYPHILIS

Special serologic tests for syphilis in the laboratories of the Georgia Department of Public Health consist of a battery of standard reagin tests and the Treponema Pallidum Immobilization (TPI) test. Since both of these services are relatively expensive and time consuming, they are reserved for cases in which the results of routine serologic testing for syphilis appear to be incompatible with the clinical status of the patient.

The battery of reagin tests, consisting of established standard tests of this type, is performed once each week in the central (Atlanta) laboratory only.

The TPI test is available at the Venereal Disease Research Laboratory, U.S. Public Health Service, only by referral through our central laboratory. The results are reported to us for transmission to the sender.

Criteria for Acceptance of Specimens for Special Testing

1. Routine serologic tests have given reactive or weakly reactive results in two or more testings, spaced seven to ten days apart, and are not supported by clinical or historical evidence of syphilis.

2. Patient must not have received injected antibiotics within one month or oral antibiotics within one week of date specimen is collected.
3. In order that a decision can be reached as to the testing procedures to be employed, entries must be made in all items of the data sheet which accompanies the specimen.

Upon receipt of specimen a portion of the serum will be reserved for TPI testing and the remainder used for the battery test. The results of the battery test will be reviewed in the light of the data submitted with the specimen and when indicated, the serum will be referred for the TPI test.

This procedure requires only one collection kit and only one specimen for complete special serologic testing for syphilis. It should provide a more convenient and efficient service to both physician and patient.

Collection kits may be obtained, as in the past, from the Central laboratory in Atlanta, or from the Regional laboratories in Macon, Waycross and Albany.

**Whatever happened
to handkerchiefs?**



Remember when handkerchiefs were used for stuffy or runny noses? *That was before Naldecon.* Naldecon lets your head-cold patient breathe the way he should. Through the nose. Honest relief that lasts up to 8 hours with one sustained-action tablet. (When you need it, even *half* a tablet retains the sustained-action feature.) The counterbalance between *two* antihistamines and *two* decongestants* usually gives excellent results—seldom causes overstimulation or sedation. Keep handkerchiefs for showing. Prescribe Naldecon.

*Each tablet contains phenylephrine HCl 10 mg., phenylpropanolamine HCl 40 mg., phenyltoloxamine citrate 15 mg., chlorpheniramine maleate 5 mg.—half in the outer layer, half in the sustained-action core. Each teaspoonful (5 cc.) of Naldecon Syrup contains the equivalent of one-half tablet.

NALDECON[®]
long-acting nasal decongestant/
antihistamine

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Syracuse, New York



1962-63 CALENDAR OF MEETINGS

State

- October 19—Annual State Meeting of the Georgia Society for Crippled Children and Adults, Brunswick Room, Atlanta Americana Motor Hotel, Atlanta. Luncheon 12:15.
- October 23, 1962-March 14, 1963—Series of Postgraduate Courses presented by the Medical College of Georgia's Department of Continuing Education: October 23-25—"Clinical Pathology In Medical Practice;" November 13-15—"Diagnosis and Practical Management of Arthritis;" December 4-6—"Orthopedics in General Practice."
- October 25-27—14th Annual Session of the Georgia Academy of General Practice, Atlanta Americana Motor Hotel, Atlanta.
- October 31-November 3—American Society of Tropical Medicine and Hygiene, Atlanta Biltmore Hotel, Atlanta.
- November 29-30—Fourth Annual Postgraduate Course in Ophthalmology of the Emory University School of Medicine, Grady Memorial Hospital, Atlanta.
- February 17-20, 1963—Atlanta Graduate Medical Assembly, Atlanta Biltmore Hotel, Atlanta.
- May 5-8, 1963—109th Annual Session of the Medical Association of Georgia, Buccaneer Motor Lodge, Jekyll Island, Georgia.**

Regional

- October 17-18—American College of Preventive Medicine, Inc., Hotel Fountainebleau, Miami Beach, Fla.
- October 19-21 — 13th Annual Scientific Assembly, Florida Academy of General Practice, Deauville Hotel, Miami Beach, Fla.
- October 29-31—American Association for the Surgery of Trauma, The Homestead, Hot Springs, Va.
- November 9-10—Southern Society for Pediatric Research, Gainesville, Fla.
- November 11-12—Southern Chapter of the American College of Chest Physicians, Annual Meeting, Hotel Fountainebleau, Miami Beach, Fla.
- November 12-14—Association of Military Surgeons, 69th Annual Meeting, Mayflower Hotel, Washington, D. C.
- November 12-15—Southern Medical Association, Hotel Fountainebleau, Miami Beach, Fla.
- November 14 — Medical Society of the District of Columbia, Washington, D. C.
- November 15-17—Southeastern States Cancer Seminar, George Washington Hotel, West Palm Beach, Fla.
- November 16-17 — Fourth Annual Meeting, Florida State Surgical Division, International College of Surgeons, University of Florida College of Medicine, Gainesville, Fla.
- January 20-25, 1963—American Academy of Orthopaedic Surgeons, Americana Hotel, Bal Harbour, Miami Beach, Fla.

National

- October 17—Society for Adolescent Psychiatry, New York City.
- October 20-26 — Annual Otolaryngologic Assembly, postgraduate course, University of Illinois College of Medicine, Chicago, Ill.
- October 21-26—American Society of Anesthesiologists, Inc., Statler Hilton Hotel, New York City.
- October 22-23 — American Cancer Society, Biltmore Hotel, New York City.
- October 22-26—American College of Chest Physicians, postgraduate course, Clinical Cardiopulmonary Physiology, Knickerbocker Hotel, Chicago, Ill.
- October 26-30 — American Heart Association, Inc., Sheraton-Cleveland Hotel, Cleveland, Ohio.
- October 27-November 1—American Academy of Pediatrics, Palmer House, Chicago, Ill.
- October 28-31—American College of Gastroenterology, The Morrison, Chicago, Ill.
- October 31-November 3 — Congress of Neurological Surgeons, Shamrock Hilton Hotel, Houston, Texas.
- November 1-2—American Rhinologic Society Annual Meeting, Statler Hilton Hotel, Los Angeles, Calif.
- November 3-4 — State Medical Editor's Conference (fourth), Denver Hilton Hotel, Denver, Colo.
- November 4-9—American Academy of Ophthalmology and Otolaryngology, Las Vegas Convention Center, Las Vegas, Nev.
- November 7-10 — Conference on "Fetal and Infant Liver Function and Structure," under the auspices of the New York Academy of Sciences, Henry Hudson Hotel, New York City.
- November 9-13—American Otorhinologic Society for Plastic Surgery, Inc., Ambassador Hotel, Los Angeles, Calif.
- November 15-17—Southern Thoracic Surgical Association, Arawak Hotel, Ocho Rios, Jamaica, B.W.I.
- November 24-25—American College of Chest Physicians, Annual Interim Session, Ambassador Hotel, Los Angeles, Calif.
- November 25-28 — American Medical Association Clinical Meeting, Los Angeles, Calif.**
- November 29-December 2—American Medical Women's Association, Ambassador Hotel, Los Angeles, Calif.
- December 1-6—American Academy of Dermatology, Inc., Palmer House, Chicago, Ill.
- December 3-5—Association for Research in Ophthalmology, University of Michigan Auditorium, Ann Arbor, Mich.
- December 4-6—Southern Surgical Association, Boca Raton Hotel, Boca Raton, Fla.
- December 7-9—American Psychoanalytic Association, Commodore Hotel, New York City.
- January 18, 1963—American Society of Facial Plastic Surgery, Hotel Elysee, New York City.
- June 16-20—AMA Annual Meeting, Atlantic City, N. J.

1963 Annual Session

May 5-8, 1963 — Aquarama, Jekyll Island, Georgia



Second Call for Scientific Papers

All titles must be submitted to the
respective program chairmen listed
below before November 1, 1962

ANESTHESIOLOGY

Bert H. Ellis, M.D.
3043 Sherwood Drive, Brunswick

CHEST

John A. Hightower, M.D.
2601 Parkwood Drive, Brunswick

DERMATOLOGY

Marvin F. Engel, M.D.
11 Professional Building, Brunswick

DIABETES

Haywood L. Moore, M.D.
2601 Parkwood Drive, Brunswick

GENERAL PRACTICE

Milledge Smith, M.D.
801 Mansfield Street, Brunswick

MEDICINE

Arthur M. Knight, Jr., M.D.
P. O. Box 899, Waycross

OBSTETRICS AND GYNECOLOGY

George B. Wheeler, III, M.D.
10 Professional Building, Brunswick

OPHTHALMOLOGY AND OTOLARYNGOLOGY

Braswell Collins, M.D.
740 Hemlock Street, Macon

ORTHOPEDICS

L. E. Dickey, M.D.
671 Hemlock Street, Macon

PATHOLOGY

Robert E. Perry, M.D.
Glynn-Brunswick Hospital, Brunswick

PEDIATRICS

Newell M. Hamilton, M.D.
2001 Gloucester Street, Brunswick

PSYCHIATRY

Sheldon B. Cohen, M.D.
Medical Arts Building, Atlanta 8

RADIOLOGY

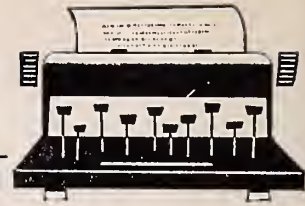
Bert H. Malone, M.D.
1406 Reynolds Street, Brunswick

SURGERY

E. R. Jennings, M.D.
2601 Parkwood Drive, Brunswick

UROLOGY

Woodrow W. Payne, M.D.
Masonic Building, Brunswick



How Well Are We Telling Our Story?

IN JULY THE MEDICAL profession won an important battle in the United States Senate on the issue of Social Security medicine—but the war goes on. To win the war, we as physicians must explain our side of the story to the public. In order to inform *Journal* readers of the progress being made in this area of communication by the medical profession, as they speak to various civic and professional groups throughout the state of Georgia, the *Journal of The Medical Association of Georgia* is beginning a new feature entitled, “How Well Are We Telling Our Story?”

Each month a small map of Georgia will be featured with locations listed showing the various, and we hope numerous, places where doctors have spoken in the fight against King-Anderson type of legislation or on any other subject of public interest. It is the responsibility of each doctor to do his fair

share in saturating the map of Georgia with stars. No individual speaker's names will be listed, only the names of towns and counties where talks have been presented. It is the hope of the *Journal* staff that each month the map will be literally “peppered” with stars, an indication that we as a profession are reaching the people with our story. By pointing up where and how often such talks are taking place, we hope to accurately mirror the action or inaction of our doctors in this essential area of communication.

By speaking to the people of Georgia, we may assume a more active and effective role in public affairs. How active are you in civic affairs; how effective are you? If the medical profession does not tell its own story, who will? How well are we telling our story? It is up to us to determine how significant a contribution, through communication, we can make to public affairs.

Proctosigmoidoscopy

RECTAL AND PROCTOSIGMOIDOSCOPIC examinations are now the most reliable methods of detecting carcinoma of the distal colon. Seventy to 80 per cent of all colonic carcinomas should be so visualized. Detection, especially early detection, is most important since 70 per cent of colon carcinomas have already metastasized at the time of surgery.

Therefore, proctosigmoidoscopic examinations are

important, not only in symptomatic persons, but probably more so in asymptomatic people on routine physical examinations. Recent reports on 3,300 such examinations on routine physicals revealed a significant number of pathological findings, and all in asymptomatic people. Another author found one case of carcinoma in an average of every 200 asymptomatic cases proctosigmoidoscoped. This ratio is about the same as that for malignancies

found on routine Papanicolaou smears of the cervix, certainly an accepted part of the routine physical examination of the female patient.

The procedure of the proctosigmoidoscopic examination should be made simple. Thorough preparation of the patient both psychologically and mechanically is considered of the utmost importance. Explanation of the procedure usually suffices. Mechanical preparation may be unnecessary if the patient has had recently a "complete" bowel movement. Otherwise, a low tap water enema until returns are clear should be ample. Digital examination should precede the introduction of the instrument not only to dilate the sphincter but to be sure the lumen is patent. The instrument should never be passed beyond this level until the light is in place, and then the passage should be made only under direct visualization. During the passage of the instrument, it is wise to

remember that the anal sphincter is pain sensitive; it also acts as the fulcrum during the examination. Allowing for gradual relaxation and dilatation of the sphincter, gentle movements on the sphincter (once it is passed), and avoidance of pressure upon the gut walls, all make the procedure painless. In addition, the patient should be urged "not to help," not to bear down, and to keep the abdomen as relaxed as possible. These factors can make the current procedure easily bearable and future procedures acceptable.

J. H. Hilsman, M.D.

References

1. Cameron, A. B.: A Cytological Method of Diagnosis of Carcinoma of the Colon. *Dis. of Colon and Rectum*. 3:230; 1960.
2. Creek, D. W.: The Value of Routine Proctosigmoidoscopy. *Am. J. of Gastroenterology*. 32:357; 1959.

Herpes Simplex

THE VIRUS OF HERPES SIMPLEX is one of the commonest infectious agents of man. There are two types of clinical herpetic disease, regardless of site infected, which are clearly differentiated. (1) Primary infections with the virus, occurring in persons without neutralizing antibodies in their blood stream, (2) recurrent attacks, occurring in persons with such neutralizing antibodies.

In a primary attack, the local lesion is usually accompanied by a systemic illness that is often severe and sometimes fatal; whereas the patient with a recurrent attack, however severe the local lesion may be, is as a rule singularly free from systemic symptoms.

These factors are common to all the manifestations of the disease:

- (1) tissues preferentially attacked are those of the embryonic ectodermal layers.
- (2) visible manifestations when present are characterized by vesicle formation in the epithelial layers.
- (3) lesions are histologically characterized by intranuclear inclusion bodies and
- (4) the virus can be isolated with relative ease from infected tissues.

The virus of herpes simplex has been regarded as a highly successful parasite. Certain patterns in host-parasite relationship have become established which

assure the perpetuation of the parasite population without profoundly disturbing the host population. It is apparent that a reservoir of considerable magnitude is maintained from which the infectious agent is constantly disseminated. Individuals with primary herpetic infection provide a rich source of virus for considerable periods of time. Children in the younger age groups, especially, constitute temporary "normal" carriers at frequent intervals. Cases of recurrent herpetic infection are additional sources from which the virus is spread.

Saliva and feces appear to be the chief vehicles of transmission. Environments in which low hygiene standards and crowding prevail provide the best opportunities for a more efficient dissemination of the virus. Under these circumstances the majority of the host population becomes actively immune either by developing the primary type or from inapparent infections. This natural process is delayed where improved hygiene and absence of crowding interferes with the transmission of the virus. It has been postulated that the persistence in a latent state is one of the mechanisms which serves to maintain herpes virus in its human host. It is evident that if herpes virus becomes established in a latent state following primary infection it does not serve as a stimulus for maintaining a persistently high level of neutralizing antibodies.

Placental transmission has been demonstrated to establish passive serologic immunity in the newborn infant. Passively acquired antibodies appear to be an important factor in providing protection against primary infection during the first six-12 months of life. The incidence of passive immunity in the infant population develops in direct proportion to the incidence of actively acquired immunity in the adult population. It remains to be determined whether inapparent infections capable of stimulating immunity may become established in infants in whom passively acquired antibodies have reached a low level. Such a demonstration could explain the general impression that many children escape the primary infection in overt or manifest form and nevertheless have acquired active immunity.

Maximum antibody titres are usually attained during the second or third week following the onset of the disease. Following this the titre drops to low levels after which more or less fluctuation is observed. Herpes simplex virus is recovered from the mouths of many individuals presenting no clinical evidence of the infection.

It is now recognized that herpes simplex virus is not only dermatotropic but may produce a generalized infection. This generalized infection is most likely to occur in the neonatal period, and especially in premature infants. This herpetic infection may be contracted by the newborn in two ways: either they are born without immunity because antibodies are lacking in the mother, or due to prematurity, the tissues are especially susceptible to the virus. Herpetic infection in the newborn may be commoner than generally believed and may even be the cause of some unexplained deaths or cases of encephalopathy with psychomotor sequelae.

The average age at onset is about seven days and there is evidence of maternal herpes infection in 50 per cent of the cases.

The diagnosis should be considered whenever lesions of the skin and mucosa, with signs of visceral involvement and or possible involvement of the nervous system are found in a newborn infant, especially in a premature infant. Herpes may be a starting point of a severe generalized illness in an infant but metastatic dissemination of the virus is rare with only 14 cases having been reported in the literature.

CANCER TREATMENT MAY BE AVAILABLE SAYS PHYSICIST

Specialized clinic type cancer treatment may be available in every American village, and even in remote areas of the world, with the application of a Lockheed-Georgia physicist's nuclear engineering techniques which hold promise of revolutionizing radiology therapy.

The Lockheed Nuclear scientist's proposals were outlined in a paper, delivered by D. E. Kahlson, of Lockheed-Georgia's Nuclear Branch, before the Eighth International Cancer Congress in Moscow, Russia, recently.

Besides Kahlson, co-authors of the paper entitled "Radiotherapy with Liquid Isotopes," were Drs. W. B. Nalley, Hall County Hospital, Gainesville, Georgia, and A. Raventos, University of Pennsylvania Hospital, Philadelphia.

Treatment of many parts of the body affected by cancer, especially in women, fail or are only partially effective because of their inaccessibility to require dosages of radiation. Furthermore, serious damage to surrounding tissue can occur when radiation dosage is directed toward the affected part.

A series of applicators, each designed specifically for individual body organs would lessen this danger, increase curative powers with less radiation, and provide a wider range of isotope application than is possible with today's equipment, Kahlson told the Moscow meeting.

These applicators would be designed to permit insertion in natural body openings or surgical incisions, said Kahlson. Design of these applicators, coupled with a portable shielded storage cask, would permit use

of a wider range of isotopes, previously prohibited because of danger to patient and therapist alike.

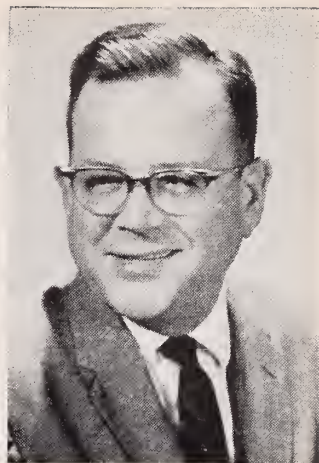
The proposal of the scientist, a Gainesville, Georgia, resident, would develop six of these basic isotope transport units under the sponsorship of a government or national health agency. These units would be equipped with applicators for the treatment of cervical carcinoma, post-operative chest wall irradiation, deep tumors and superficial lesions. All other applications would be of a continuing research nature.

Produced on a mass production basis, these units would sell for an estimated \$6,000, making them available to hospitals in the most modest budget range, Kahlson predicted.

Units would serve both as storage cells for isotopes and for the mechanical transfer of selected isotopes to applicators. Quick disconnect loops would prevent leakage of liquid isotopes, yet enable separation of the applicator, once it is properly inserted, from the unit. This feature permits one unit to serve several patients at the same time.

The unit, weighing about 4,000 pounds due to radiation shielding, would operate in conjunction with a high-speed computer system. This system would produce rapid three dimensional isodose contours for each loaded applicator.

With this predetermination of radiation flux wave contour, it will be possible to adjust shielding in the applicator. This permits control of radiation toward the effected part, with a minimum of radiation dosage to surrounding organs.



"LET'S NOT BOG DOWN NOW"

AS ANY GOOD TRACK AND FIELD COACH will tell you, distance races are won by that extra effort put forth when the finish line comes in view. Unlike the short sprints where the fast start is all important, the long run calls for an ability to "turn it on" in the last lap and not only out-distance but overtake your competitor.

I believe a good comparison can be made here with the "long haul" fight by the medical profession to resist encroachment and ultimate control by the Federal Government.

We have made a creditable, even inspiring run in the marathon King-Anderson race. The finish line may be in view within the early months of the next Congress. Now is the time to turn on the steam for a fast finish calculated to insure a few years' respite from what has become a never ending battle for the control of the medical profession.

As everyone knows, the medical profession is not numerically strong enough to be a potent factor in the way of political opinion. However, as opinion leaders and opinion moulders, physicians rank alongside the best in the business. This great reservoir of strength presents us with our best opportunity to build a "climate" in which legislation of the compulsory King-Anderson nature would wilt and die on the vine.

The cultivation of a proper climate cannot be accomplished, however, by doctors merely talking to other doctors. This is not the battleground. The battlefield is in the great market place of the public-at-large; the civic clubs, the trade and professional groups; friends and patients. This is where the fight will be won or lost. If the great majority of the body politic can be enlisted as spiritual allies, then no politician would dare suggest that the Congress move to enact such legislation as the King-Anderson, Forand, or Murray-Wagner-Dingle Bills. The first law of politics is to get and stay elected—it is not to crusade in behalf of things the people don't want.

In the immediate future the *Journal of the Medical Association of Georgia* will begin running a monthly feature designed to highlight those areas in the State where physicians are putting forth that extra effort to keep the general public informed of the "doctor's side of the story."

This feature will not, of course, influence public opinion. It will merely serve as a mirror to reflect the efforts of doctors to fight their own battles. It will at the same time point out where we are falling down on the job—or where we have adopted a "let George do it" attitude. I urge each member of MAG to reassess his position in the struggle to win the minds of the public and to build grass roots support for the position medicine has taken in this matter.

I urge each of you to be receptive at all times to every opportunity. The King-Anderson fight is not a dead issue. The public is well aware of this and for the most part still welcome constructive, critical analysis of the bill itself and the total problem of which the bill is a part.

Dr. W. Goodwin
President, Medical Association of Georgia



PSYCHIATRY, THE FAMILY, AND RELIGION

C. F. Midelfort, M.D., *LaCrosse, Wisconsin*

INTEGRATION, the coming together of different levels of reaction to form a new whole, is a concept basic to medicine, psychotherapy, sociology, and cultural anthropology. Any activity or reaction must be understood as involved in the many levels of integration of the unit whether expressed in an organ, a body, a person, an individual, a self, a family, or a religion. A word, hallucination, or a physical symptom, for example, reflects physical and chemical functions of an organ, the maintenance of the physical life of a body, the expression of a person through his conscious and unconscious reactions and the reactions of several organisms in a family and in a church.

Mental Illness Shared

The family is the unit with which both the pastor and the psychotherapist are concerned. Mental illness and religion are shared by members of a family in great detail and depth. Gestures, tones of voice, ways of walking, types of humor, values, attitudes, unconscious and conscious reactions, feelings about faith and justification, to mention but a very few, are a part of common personality patterns found in the health expressed by a family.

The various levels that function together are not all syntonetic, syncretic, or synthetic in character. Paradoxes exist in which opposites are equally valid and these are present in theology, philosophy, psychiatry, medicine, and chemistry, the sciences involved in these levels of integration. The resolution of the paradoxes by allowing only one side to exist while the other is denied or suppressed results in ill health.

We are completely dependent on God, possessed by Him, at the same time as we are fully responsible ourselves for every decision and action that we make. We are completely dependent on the love we receive

within the family and church and we are fully responsible for our own lives. We are totally dependent on our chemistry and at the same time we determine and modify it medically. We rely on that nature given to us and we decide how that nature shall be controlled by us.

A Contribution

Religion and psychiatry, as well as medicine in a broader sense, must contribute to each other's education and development. There are many ministries and in this busy, crowded world several ministries must come together in order that the worship of Christ may be experienced not only in the church but also in all areas of healing and service in which the laity takes part. Family therapy is one example of such a joint ministry.

In a world where the sick and well, pastor and psychiatrist, lay and professional persons, are all pushed together, each must be witness to the other about both sides of the paradoxes that complicate and deepen the many dimensions of our lives.

Depth and Meaning

The levels of integration and relationship of a family and the people with whom it is associated give depth and meaning to life. The effort to be comfortable and secure, free from fear, want, and tyranny is wasted if conflict is eliminated. To withdraw from life and its problems by seeking security in a small or big town as an individual or group member, though one may keep busy in the process, will bring on spiritual, mental, and physical ills. Those who advocate individualism, communism, or war have decided that security and comfort are bad for the organism. However, they are fighting the wrong fight. They choose to externalize or internalize what is actually the opposite. Communism externalizes the

conflict that belongs within the person and group, while individualism internalizes conflicts that are social and cultural. If we meet our problems where they exist, in our culture, our society, and ourselves, individualism and communism will be words that do not describe our condition where we are living today. Like the church which has been defined exclusively in terms of preaching and the sacraments when serving others wherever they are is as much the worship of God, communism and individualism represent a living in the past when hurt feelings and worries were different from what they are today.

Dehumanized World?

Our world is called dehumanized but usually by those who think of humanism as fixed and rigid images created in the past. The individual, the reduction of his problems of the past through the internalization of cultural factors within unconscious reactions, is also a cultural movement valid during a transitional period of withdrawal and defense against the

changing times. Psychoanalysis with its leisurely and time-consuming concentration upon the inner world of a person is already outmoded excepting where it throws light on certain restricted levels of integration, especially the social and biological levels. This artificial preparation for life is only as valid as a judgment about the world on which it is based. The criticism of "Family Therapy" has been that families no longer exist in the sense of a secure, rural, homogeneous group. The family group already is expanded to include others outside the family and "Family Therapy" has also gone out beyond the family to include pastors and others (psychologists and social workers) with whom a patient and family are involved. It needs to go much further in its collaboration with others.

Georgia has made its contributions in this area and it is a privilege for one from Wisconsin (An American of Norwegian descent, a psychiatrist and a member of the American Lutheran Church) to share his ideas with you.

Prepared at the Request of the Committee on Mental Health of the Medical Association of Georgia.

PHYSICIANS PROBE INDUSTRIAL HEALTH PROBLEMS

Many executive heart attacks can be avoided, according to Dr. Irvine H. Page, former President of the American Heart Association.

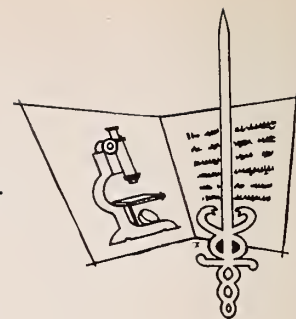
Discussing heart disease in industry in a new booklet titled, "Your Physician Looks at Health and Productivity," published by The American College of Physicians, Dr. Page offers ten suggestions "that may help you not to have a heart attack." He points out that, as a result of medical advances in the last two decades, cardiovascular disease, if it occurs, need not be wholly incapacitating.

A medical organization which represents more than 11,000 specialists in internal medicine and related fields, The American College of Physicians has called upon five of its distinguished Fellows to analyze the increasing problem of industrial losses resulting from employee illness.

In addition to Dr. Page, other contributors are Dr. William C. Menninger, Topeka, Kansas, President of the Menninger Foundation, who reviews mental illness and

its inter-relation to physical illness; Dr. Wesley W. Spink, Minneapolis, Minnesota, Professor of Medicine at the University of Minnesota Medical School, who advises on the prevention and control of infectious diseases; Dr. Lemuel C. McGee, Wilmington, Delaware, Medical Director of the Hercules Powder Company, who stresses the importance of preventive medicine and physical fitness; and Dr. Howard A. Rusk, Chairman, Department of Physical Medicine and Rehabilitation, New York University College of Medicine, who urges industry to make use of the abilities of retired persons and the partially disabled.

The material presented in the booklet has been adapted from a Public Information Forum on Health and Productivity, presented in April 1962, under the auspices of The American College of Physicians and the Chamber of Commerce of Greater Philadelphia. Complimentary copies are available for limited distribution from the College headquarters, 4200 Pine Street, Philadelphia 4, Pennsylvania.



GETTING THE POTENTIAL CANCER PATIENT TO ACT IN TIME

A. H. Letton, M.D., *Atlanta*

MOST OF US HAVE SEEN FAR TOO MANY PATIENTS with cancer too advanced for cure, who might have been saved if they had only come to us a few months, or even a few weeks earlier. The number of cancer patients being saved today compared with the number who could be saved through earlier diagnosis and treatment affords a great challenge.

The American Cancer Society, with its volunteer force numbering in the hundreds of thousands, is trying to meet this challenge. Here in Georgia this fall and winter a well-planned and organized effort is being launched to alert people to the dangers of the cancer threat and to motivate potential cancer victims to go to their physicians at the earliest possible moment.

This fall-winter "Earlier Treatment Education Program" has no relation to the Cancer Society's fund-raising efforts, and the materials used in it — films, leaflets, posters, displays, newspaper articles, radio and TV announcements — do not even mention fund-appeals. Its only purpose is to save additional lives from cancer by urging people to get earlier treatment.

The Society's County Units throughout Georgia will take the program to their people through the mass communications media, business firms, clubs and organizations and schools and colleges. Special committees are being organized to work in each of these areas.

Another essential committee for each County Unit to make the program effective is a Medical Speakers Panel. Panel members would make talks on cancer

at meetings of clubs, employee groups, etc., and be present at cancer educational film showings to answer questions from the audience after the film is presented. This type of doctor-film program has proven most effective in alerting people to the best ways to guard their lives against needless cancer death.

The Society strongly recommends that its Units have a physician present at showings of three of its educational films. They are, "Life Story" on Colon and Rectal Cancer, "Time and Two Women" on Uterine Cancer, and "Breast Self-Examination." The opportunities of increasing the cure-rates for these sites of cancer through earlier detection and treatment are well known to all of you.

If you are asked to serve on the Medical Speakers Panel of your County Unit of the Cancer Society, please say "yes." I assure you, you will find it a rewarding experience, as well as improving your own public relations and that of the medical profession. When the public sees one of us giving our time and talents for their benefit, it helps in making them feel more kindly toward doctors, medicine in general, and the Cancer Society.

We are a long way from having a final solution to the cancer problem. But the one-in-three cancer patients being cured today is great progress over the one-in-seven which were being cured not too many years ago. A major factor in this progress has been increased efforts to inform the general public about cancer. Further progress will surely come as these educational efforts are increased.

Approved by Professional Education Committee, Georgia Division, ACS.



ABDOMINAL AORTIC ANEURYSMS

J. Harold Harrison, M.D., *Atlanta*

ARTERIOSCLEROTIC ANEURYSMS occur most frequently in the abdominal aorta, more than 98 per cent arising below the renal arteries which makes them readily accessible to resection and replacement with a prosthesis.

The symptoms are variable and are produced by compression of the surrounding structures, thrombosis, embolization, or rupture. The most frequent are back or flank pains due to posterior extension and compression of lumbar nerves or repeated bouts of dissection or leakage in the walls followed by sealing off. Severe back or abdominal pain followed by hypotension implies rupture which, in too many instances, is the first presenting symptom. Abdominal aneurysms and their complications may mimic the symptoms of most intra-abdominal pathology.

Pulsating Abdominal Mass

The most common physical finding is a pulsating abdominal mass. The prominence of this depends upon the build of the patient and, in the obese, many are not detected until they are of large size or have developed complications. X-ray evidence of calcification in the walls is present in 70 per cent and may be the first diagnostic clue. Oblique and lateral X-rays are more reliable than AP views.

Once the aortic wall becomes weakened and dilates a vicious cycle is developed. The lateral pressure on a given area of a tube is in direct proportion to the fourth power of its radius. The increased pressure caused by dilatation produces further weakening of the wall and rupture is the ultimate outcome if the patient does not die of other causes. Thrombi form in the lumen of many, which may decrease the

lateral pressure; otherwise, all would rupture in a short period of time. In separate reviews by Estes and Wright of 170 patients with aortic aneurysms it was found that 35 per cent were dead within one year, 50 per cent in two, and 85 per cent in five years, regardless of the size or symptoms. Death in 65 per cent of these patients was directly attributable to the aneurysms.

Investigators' Prognosis

Most of the other investigators have reported a poorer prognosis and have been able to correlate it with the present findings. Seventy to 80 per cent of patients with aneurysms over seven cms. in diameter will die of complications of their aneurysms, but this percentage will drop to 20 to 30 per cent in patients with aneurysms of less than seven cms. in diameter. Reports of the prognosis after the development of symptoms are variable and, of course, would be somewhat dependent on the individual evaluation of the patients studied. A review of the material available implies that once significant pain has developed 50 per cent will die of rupture within six months and 80 per cent within one year after the onset. There is little doubt that significant pain or progression in size are bad prognostic signs.

Surgery of aortic aneurysms consists of resection and replacement with a prosthesis. Vascular surgical techniques have improved to the point that the operative trauma and risk of this is comparable with that of other major intra-abdominal procedures, such as gastrectomy or colectomy. The operative mortality is determined, therefore, primarily by the general status of the patient. This is no small problem, as

more than 50 per cent of the patients with aneurysms have evidence of arteriosclerosis elsewhere, involvement of the coronary and cerebral vessels presenting the primary limiting sites. Contrary to some previous opinions, these people tolerate surgery surprisingly well if they are compensated, have no acute myocardial damage, and optimum conditions can prevail during surgery. The operative mortality in reasonably good risk patients is five per cent.

Rupture of aneurysms in most of the patients who reach the hospital alive occurs retroperitoneally. Many will live long enough for the institution of definitive surgery. Once rupture has occurred, however, the mortality rate under the best of circumstances is 40 to 50 per cent.

Which Will Kill First?

The selection of patients for surgery is either easy or extremely difficult. One must basically decide which will kill him first—his aneurysm or disease elsewhere and then correlate this with the operative mortality and morbidity. Unfortunately, it is not possible in any given individual to tell what the fate of his aneurysm will be. Small ones, as well as large ones, can and do rupture. An opinion in most instances can be based only on the available statistics combined with careful clinical judgment.

The following are criteria for selection of patients for surgery utilized by the author, based on results both good and bad, in the treatment of more than 100 patients with abdominal aortic aneurysms:

1. Good risk patients—aneurysm regardless of size and symptoms
2. Ruptured aneurysms—all should be attempted, as the patients are dead otherwise and we are working on a salvage basis. A 50 per cent chance is better than none.
3. Poor risk or borderline patients—large, expanding, or symptom-producing aneurysms, particularly if the patient lives in an area where he cannot be gotten quickly to a hospital where facilities for rapid blood replacement and aortic surgery are available.

Surgery for aortic aneurysms has passed the experimental stage and, when feasible, offers the best chance of comfortable survival to persons with this crippling and often fatal disease.

Any decision for non-operative treatment, particularly in the good risk patient, should be supported by statistics giving a more favorable outlook than has been previously reported. If such information is available, it should be reported for the benefit of all. Until this is documented, one must consider the non-operative approach similar to gambling "against the house" with some one else's life.

Prepared at the Request of the Committee on Professional Education of the Georgia Heart Association.

CHEST PHYSICIANS ISSUE

STATEMENT ON CIGARETTE SMOKING

The Committee on Cancer of the American College of Chest Physicians for a number of years has been studying the effect of cigarette smoking on the pulmonary and cardiovascular systems. The members of the Board of Regents of the College are convinced that sufficient evidence has been accumulated to warrant issuing an official statement with regard to cigarette smoking and health. Accordingly, a resolution connecting cigarette smoking with various pulmonary and cardiovascular conditions was approved by the Board and issued by the College.

The resolution stated that the weight of scientific evidence distinctly indicates that cigarette smoking and the inhalation of other atmospheric pollutants have an association relationship which strongly suggests a causal connection with chronic bronchitis, pulmonary emphysema, cor pulmonale, cardiovascular diseases and cancer of the lung.

The College in its official statement urged its members

and the medical profession in general to intensify their educational campaign directed toward the public, and the youth in particular, relative to the hazards of smoking.

The College urges that efforts to control atmospheric pollution be encouraged and that support be given to endeavors in the field of research for additional scientific information concerning other etiologic agents.

The resolution was introduced by Dr. J. Winthrop Peabody, Jr., Washington, D. C., to the House of Delegates of the American Medical Association and was referred to their Council on Drugs which is conducting a study on the relationship between tobacco and disease. A preliminary report is to be presented by the Council within 12 to 18 months. Surgeon General Luther L. Terry of the U. S. Public Health Service has announced plans for an advisory committee to make recommendations on the health aspects of smoking. The College resolution will be referred to this committee.



BOOKS RECEIVED

Cantarow, Abraham, M.D., and Trumper, Max, Ph.D., **CLINICAL BIOCHEMISTRY**, Sixth Edition, W. B. Saunders Co., Philadelphia and London, 1962, 776 pp., \$13.00.

Kline, Nathan S., M.D., and Lehmann, Heinz, M.D., **Handbook of PSYCHIATRIC TREATMENT IN MEDICAL PRACTICE**, W. B. Saunders Co., Philadelphia and London, 1962, 124 pp., \$3.50.

Gibbon, John H., M.D. with the collaboration of 35 authorities, **SURGERY OF THE CHEST**, W. B. Saunders Co., Philadelphia and London, 1962, 902 pp., \$27.00.

Huffman, John William, M.D., **GYNECOLOGY AND OBSTETRICS**, W. B. Saunders Co., Philadelphia and London, 1962, 1190 pp., \$28.00.

Parsons, Langdon, M.D., and Sommers, Sheldon C., M.D., **GYNECOLOGY**, W. B. Saunders Co., Philadelphia and London, 1962, 1250 pp., \$20.00.

Wolff, Louis, M.D., **ELECTROCARDIOGRAPHY**, Fundamentals and Clinical Application, Third Edition, W. B. Saunders Co., Philadelphia and London, 1962, 351 pp., \$8.50.

Allen, Edgar V., M.D.; Barker, Nelson, W., M.D.; and Hines, Edgar A., Jr., M.D., **PERIPHERAL VASCULAR DISEASES**, Third Edition, W. B. Saunders Co., Philadelphia and London, 1962, 1044 pp., \$18.00.

Novak, Edmund R., M.D., and Woodruff, J. Donald, M.D., **Novak's GYNECOLOGIC AND OBSTETRIC PATHOLOGY with Clinical and Endocrine Relations**, Fifth Edition, W. B. Saunders Co., Philadelphia and London, 1962, 713 pp., \$16.00.

Somers, Herman Miles, and Somers, Anne Ramsey, **DOCTORS, PATIENTS, AND HEALTH INSURANCE**, Doubleday & Co., Garden City, New York, 1962, 544 pp., \$1.95.

CIBA Foundation Study Group No. 12, **CURARE AND CURARE-LIKE AGENTS**, Little, Brown & Co., Boston, 1962, 103 pp., \$2.95.

CIBA Foundation Symposium on **THE ENDOCRINE PANCREAS**, Normal and Abnormal Functions, Little, Brown & Co., Boston, 1962, 390 pp., \$11.50.

Chusid, Joseph G., M.D., and McDonald, Joseph J., M.D., **CORRELATIVE NEUROANATOMY and FUNCTIONAL NEUROLOGY**, Lance Medical Publications, Los Altos, Calif., 1962, 384 pp., \$5.00.

Medical Department, United States Army, **SURGERY IN WORLD WAR II, Activities of Surgical Consultants**, Volume I, Office of the Surgeon General, Department of the Army, Washington, D. C., 1962, 621 pp., \$6.50.

Medical Department, United States Army, **WOUND BALLISTICS**, Edited by Major James C. Beyer, MC, Office of the Surgeon General, Department of the Army, Washington, D. C., 1962, 883 pp., \$7.50.

REVIEWS

A STUDY OF PSYCHOPHYSICAL METHODS FOR RELIEF OF CHILD-BIRTH PAIN—C. Lee Buxton, M.D., W. B. Saunders Company, Philadelphia and London, 1962, 116 pp.

THE RELIEF OF PAIN has always been one of man's more noble goals, and for the past century there has been a progressive major interest in relieving childbirth

pains. In the 30 years since Grantly Dick Read introduced his concept of natural childbirth, there has been tremendous controversy between the two basic methods: pharmacological aid for pain relief versus pain relief by psychophysical methods. Dr. Buxton has taken a sabbatical year to study and evaluate the theories, practices, and results of clinics practicing psychophysical training in the United States and most European and Scandinavian countries. This book is a report of his impressions. The subject is very timely because of the increased interest of both the obstetrician and the patient concerning the possible harmful effects of analgesia and anesthesia.

The author deals primarily with the theories and results of the four basic methods of psychophysical preparations: the Pavlovian conditioned reflex methods, natural childbirth, autogene training, and hypnosis. Many of the clinics use a combination of these methods. The specific details of education and types of exercises are not included.

The conclusions one draws from Dr. Buxton's book are that there is much to be contributed to good obstetrical care from psychophysical training and that there will be a merging of the best of the two basic methods.

Mark P. Pentecost, Jr., M.D.

BOOK REVIEW OF PEDIATRICS, by Holt McIntosh & Barnett, 1962.

THIS STANDARD textbook of Pediatrics has been almost entirely rewritten in this new edition. Its list of contributing authors is impressive and extensive and a very successful attempt at continuity of thought and philosophy has been made by the editors.

Especially good chapters, in the eyes of the reviewer, were the Circulatory System and the Endocrine System, but certainly all chapters in general are adequate. A Bibliography immediately following each section is quite helpful and indicates rather well how modern the revision has been. Of necessity, the information on antibiotics is outdated in some respects by the time the book gets into print.

A book such as this attempts to serve medical students, house officers, pediatricians, and general practitioners. This is an impossible task to do completely in one volume and may be the cause of this book's greatest weakness which is a lack of specific recommendations for therapeutic situations. Dosages are not clearly defined, indications for therapy are generalized or hedged. Use of tables for drugs, formulas, etc. (not present) could have been used to great advantage. Poisoning, one of the major causes of illness and death in Pediatrics is treated very peremptorily.

In conclusion, the book has been reworked almost completely, contains much new information, and despite some weaknesses, contains a wealth of useful

PHYSICIAN'S BOOKSHELF / *Continued*

material for the student, house officer, or practitioner dealing with children.

Robert C. Garner, M.D.

FUNDAMENTAL SKILLS IN SURGERY, Nealon, Thomas F., Jr., M.D., Associate Professor of Surgery, Jefferson Medical College, W. B. Saunders Company.

EXPERIENCE AS A practitioner and teacher has stimulated the development of this needed book. As predicted in the preface, Dr. Nealon has accomplished his goal in establishing a ready reference for the young physician who may need to perform a simple technical procedure—for practical patient care. In addition, he has presented certain emergency procedures (tracheostomy, resuscitative technics, etc.) of value to any physician where an acute problem exists requiring definitive, immediate treatment.

The author's style is clear, concise, and simple to read—while containing every bit of essential information for correct technic.

The format of the book is excellent with double-columned pages with adequate headings and sub-headings on a low gloss paper. It is liberally and extremely well illustrated.

The book should be a welcome asset to the young physician and to residents. It would be well for every hospital library to have one.

Pat C. Shea, Jr., M.D.

STRABISMUS, Symposium of the New Orleans Academy of Ophthalmology, George M. Haik, edit., C. V. Mosby, St. Louis, 1962.

THE SUBJECT MATTER herein compiled is valuable to the orthoptists and the practicing ophthalmologists. It has little value for the general practitioner and paralytic strabismus receives little consideration. Of particular value is a concise classification of nystagmus and a chapter giving aids in the diagnosis of strabismus.

P. Thomas Manchester, Jr., M.D.

Simonson, E., M.D., DIFFERENTIATION BETWEEN NORMAL AND ABNORMAL IN ELECTROCARDIOGRAPHY, C. V. Mosby Company, St. Louis, 1961, 328 pp.

THE AUTHOR who is at present Professor of Physiological Hygiene, University of Minnesota, has spent a lifetime studying the significance of the various components of

the electrocardiogram. In thousands of tracings he has studied the incidence and apparent significance of Q waves of various depths and widths, R wave amplitudes, ST depressions, T wave changes, etc., etc., and in numerous papers in the past has reported much of this work. This volume serves largely as an encyclopedia of these excellent studies.

The author presents statistics of various normal limits through which the normal and abnormal may be differentiated as far as possible. Considerable emphasis is placed on variability due to technique, and functional, physiologic, and constitutional variables. Interpretation of stress tolerance tests is discussed in considerable detail. Although the volume is largely concerned with pattern interpretation, spatial VCG is briefly discussed.

Statistical work of this sort is not entertaining reading. However, since EKG interpretation is largely empirical, competent statistical studies such as this book presents are an essential basis of correct interpretation. The author has covered his field very thoroughly and the book is well written. It would be most useful as a reference book for cardiologists, particularly those interested in the industrial and insurance fields.

Grant Wilmer, M.D.

Finneson, Bernard E., M.D., F.A.C.S., DIAGNOSIS AND MANAGEMENT OF PAIN SYNDROMES, W. B. Saunders Company, 1962, 261 pp., \$8.50.

THIS BOOK can best be described as an authoritative compendium in the diagnosis and management of all the ordinary, and some unusual, pain syndromes found not only in the course of general practice but in the specialty subjects of neurology and neurologic surgery. One is impressed by the clear-cut presentation of the basic neuroanatomy of the various tracks and pathways by which pain is transmitted. It was a very definite relief to find that this book relied considerably on the conservative management of the various pain syndromes one encounters in the average medical practice. The succinct discussions of the patho-physiology of the various types of pain patterns is very refreshing. The illustrations are highly schematic but this is advantageous in presenting the material without undue extraneous, confusing material. One can most wholeheartedly recommend this book as a very fine source material for the management of any form of pain syndrome one may encounter and, in addition, the properly applied techniques by which these problems can be managed.

Robert F. Mabon, M.D.

“JUST A REMINDER”

At the New York Annual Meeting of the American Medical Association held in June 1961, the A.M.A. House of Delegates voted the following increase in A.M.A. Membership dues: 1962—\$35.00 (for the 1962 calendar year), and 1963—\$45.00 (for the 1963 calendar year).

Therefore, A.M.A. dues for the calendar year of 1963 will be \$45.00 which is payable, along with County Medical Society dues and Medical Association of Georgia

dues, to the Secretary of your local county medical society.

MAG Membership dues will remain at \$40.00 as in past years. Statements for dues will read:

American Medical Association . .	\$45.00
Medical Association of Georgia . .	\$40.00
Conty Medical Society . . . set by your County Medical Society	



Board, John A., M.D., New Haven, Connecticut, and Butler, Charles W., Jr., M.D., Dept. of Obst. & Gynec., Emory University School of Medicine, 69 Butler Street, Atlanta 3, Georgia, "Uterosacral Block Anesthesia for Dilatation and Curettage," *Am. J. Obst. & Gynec.* 84:397-399 (Aug.) 62.

This is a report of the use of uterosacral block for dilatation and curettage in 100 patients who were liberally selected from a reasonably busy two-man service. All procedures were performed in the hospital operating room. No new techniques are described. Uterosacral block anesthesia was found to be acceptable in 77 per cent of the cases reported. The point of the paper is that this form of anesthesia is widely applicable to minor gynecological surgery and that its increased use might help to alleviate the problems of crowded operating schedules and lack of trained personnel to administer general or regional anesthesia.

Raiford, Morgan B., M.D.; Vidal, Fred L., M.D.; and Ackerly, Ernest, M.D., Ponce de Leon Infirmary, Atlanta, Georgia, "The Scope of Contact Lenses," *South M.J.* 55:862-864 (Aug.) 62.

The Scope of Contact Lenses includes:

- A. Hyperopia
- B. Myopia
- C. Mixed Optical Conditions
- D. Astigmatism
- E. Aphakia
- F. Keratoconus
- G. Bifocal Contact Lenses
- H. Prisms
- I. Age of the Patient
Ages from two and one-half to 97 years.

Summary

- A. Contact lenses offer an excellent therapeutic optical aid to the hyperopic, myopic and aphakic individual.
- B. In keratoconus it is the only optical aid of any practical value other than corneal graft surgery.
- C. Contact lenses have changed the entire concept in dealing with patients having cataracts—uniocular or binocular.
- D. Bifocal contact lenses are being improved so they are more adaptable for a wider scope of usage.
- E. By the introduction of the toric surface the astigmatic and aniseikonic corneas can be dealt with much more efficiently.

Swell, William H., M.D., and Davalos, Pablo A., M.D., Emory Hospital, Atlanta 22, Georgia, "Factors Influencing Collateral Arterial Formation From Pedicles on the Surface of the Hearts of Dogs," *Angiol.* 13:231-240 (May) 62.

Several types of pedicles containing the mammary artery were sutured to the surface of the hearts of dogs in an effort to add blood to the coronary arterial system from an extra-cardiac source. Through this approach, the basic physiologic principles governing the formation of collateral arterial channels in the body are believed to be observed more closely than was done in other procedures for the same purpose.

A pedicle containing the mammary artery, a strip of the sternocostalis muscle, connective tissue, and the mammary vein was found to be the most promising of the types tested. This pedicle was found to be capable of forming extensive collateral branches to surrounding adhesions. Thrombosis of the mammary artery did not occur if the mammary vein was included in the pedicle, and was allowed to remain open proximally.

Very few collateral channels went to the coronary arterial system. This was probably because an adequate chronic coronary arterial hypotension was not successfully produced in the animals.

Grady, Edgar D., M.D., 1938 Peachtree Rd., N.W., Atlanta 9, Georgia, "A Simple Method of Removing Plantar Warts," *G.P.* 25:89 (May) 62.

To remove plantar warts, it is suggested that they be ground out and off with a high speed motor-driven steel burr. The affected area is scrubbed with an antiseptic soap and the overlying dead callus is trimmed away with heavy scissors. The tissue under and around the wart is anesthetized by infiltrating a local anesthetic containing a vasoconstrictor. By using a magnifying glass to examine the bed at site of grinding, the physician can usually remove the last remnants of the wart.

If there is any doubt about how deep to grind, it is better to err on the conservative side. If there is a recurrence, a second minimal procedure may be done with only slight disturbance to the patient.

After the wart is removed, a pressure dressing is placed on the operative site and the feet are elevated for twenty minutes to minimize post operative bleeding. The next day this dressing is removed. Thereafter, with a soft-padded dressing on the foot and a little antibiotic ointment on the denuded site, the patient often experiences less discomfort in walking than he did before the procedure.

Wigh, Russell, M.D.; Anthony, Hubert F., Jr., M.D.; and Grant, Burton P., M.D., Medical College of Georgia, Augusta, Georgia, "A Comparison of Intravenous Urography, Urine Radiography, and Other Renal Tests," *Radiol.* 78:869-878 (June) 62.

Two new tests for the determination of renal function are described. One is called urine radiography; it had been shown previously to be an accurate measure of voided organic iodide through isotopic and chemical comparisons. The investigation compares this test with blood urea nitrogen, creatinine clearance, and phenolsulphonphthalein determinations.

The second test is the visual quantitation of intravenous pyelograms. Since urine radiography and the quantitative inspection method compare favorably, it follows that intravenous pyelography is an excellent test of renal function.

Conversely, quantitation of pyelograms is a test method in itself and as a practice is found to be one of the best methods of expressing total renal function. It can be used to assess the reasons for inaccuracies in other biological tests, including urine radiography.

Wigh, Russell, M.D., and Kennedy, William E., M.D., Medical College of Georgia, Augusta, Georgia, "Conventional Chest Films to Determine Cardiac Size," *South. M.J.* 55:581-585 (June) 62.

The many limitations in cardiac measurements tend to cast disfavor on the more complex methods and make more desirable a simple one and one which permits ready duplication at subsequent roentgen examinations.

Changes in the technical aspects of the teleroentgenograms produced for use with the Ungerleider-Clark prediction tables for heart size are recommended. These consist of using a conventional target-film distance of six feet (rather than two meters) and requesting a deep inspiratory (rather than mid-inspiratory) effort of the patient.

It is shown statistically that the mean variation between the two methods is but three per cent and the standard deviations are the same.

Advantages are discussed and it is concluded that the original tables can be used without applying a correction factor.

Durham, William F., Ph.D., and Hayes, Wayland J., Jr., M.D., C.D.C., Public Health Service, Atlanta, Georgia, "Organic Phosphorus Poisoning and Its Therapy," *Environmental Health* 5:21-47 (July) 62.

Poisoning due to organic phosphorus compounds may be encountered in relation to their use as insecticides; as chemical warfare agents; or as drugs for the treatment of abdominal distention, glaucoma, or myasthenia gravis. The principal, if not the only, pharmacologic action of the organic phosphorus insecticides is inhibition of the enzyme cholinesterase. The inactivity

ABSTRACTS / Continued

of this enzyme results in an accumulation of unhydrolyzed acetylcholine and the appearance of signs and symptoms referable to overstimulation of the parasympathetic nervous system. Oximes have been developed that are able to reverse the combination between the cholinesterase molecule and the inhibitor. The recommended one is 2-PAM chloride (2-pyridine aldoxime methochloride) now available to qualified physicians for investigational use. Since 2-PAM and atropine have complementary actions, it is best to use both in treating poisoned patients. Further details, including sources of 2-PAM, are given in an editorial entitled, "Health Hazards of Pesticides," in the July 28, 1962, edition of the *Journal of the American Medical Association*. As stated in the editorial, "For maximum usage to be made of the considerable knowledge now available on treatment of anticholinesterase poisoning, it is necessary that one of these oxime salts be made generally available for prescription by physicians in the United States."

Galambos, John T., M.D. and Cornell, Richard G., Ph.D., 36 Butler Street, S.E., Atlanta 3, Georgia, "Mathematical Models for the Study of the Metabolic Pattern of Sulfate," J. Lab. & Clin. Med. 60:53-63 (July) 62.

A mathematical model is formulated to describe sulfate metabolism in patients based on measurement of radioactivity in serum and urine following the injection of $\text{NaS}^{35}\text{O}_4$. Although the major portion of the intravenously administered radioactive sulfate is rapidly excreted in the urine, a significant portion of the administered dose is retained. It was found that in order to detect this retention and evaluate its metabolic turnover rate, it is necessary to study subjects for at least 72 hours or longer. Some of the apparently metabolized S^{35}O_4 rapidly returned to the serum indicating a fast turnover rate in a rapidly exchanging metabolic pool (REMP) while a fraction remained in a slowly exchanging metabolic pool (SEMP). Thirty-four studies were performed in five normal and 27 patients with various diseases. The metabolic patterns of sulfate, as de-

scribed by our model, are not specific for any of the diseases studied. In one patient with cirrhosis and ascites the metabolic pattern was similar in two studies performed four months apart. Another study on this subject was performed between these control studies while the patient was on glucocorticoid therapy and a marked impairment of the incorporation of sulfate in the metabolic pool was demonstrated.

Brown, Lester A., M.D., Emory Hospital, Atlanta 22, Georgia, "Mythical Sphenopalatine Ganglion Neuralgia," South. M.J. 55:670-672 (July) 62.

Sphenopalatine Ganglion Neuralgia (Sluder's Syndrome, Naval Ganglion Syndrome) is unilateral midfacial pain that MUST be located below the BROW, with or without radiation beneath the zygomatic arch, over the attachment to the ear, to the occiput, plus ipsilateral nasal congestion with noninfected discharge, and a red, watery eye. Greenfield Sluder (1865-1928, Saint Louis otolaryngologist), reasoned that the little nerve ganglion hanging from the second division of the fifth cranial nerve in the postero-lateral nasal wall was responsible, and treated by (a) applying cocaine solution on an applicator to the region of the ganglion through the appropriate naris; or, for more permanency, (b) injecting the ganglion with alcohol via a foramen in the back of the nostril using a specially shaped needle. (There are two other standard avenues for injecting the ganglion). Sluder claimed over 75 per cent good results.

The author summarized his first 28 cases: eight received cocaine nasal treatment (four helped, four not), 20 received alcohol injections (ten relieved, ten not).

This ill-defined syndrome with unconvincing statistics and possible psychosomatic factors leaves one in doubt as to whether it is actually organic with a semispecific treatment, or a mythical complaint treated by surgical psychology.

Smith, Charles W., M.D., and Sealey, R. M., M.D., 57 6th Street, N.E., Atlanta 8, Georgia, "The Clinical Significance of Class III Cervical Pap Smear," Am. Surgeon 28:420-422 (July) 62.

This paper was a review of the results and clinical followup on Papanicolaow's smear performed in the Atlanta area to determine the clinical significance of class III cervical pap smears. A method was described for obtaining an accurate pap smear and the importance of its accuracy was stressed. It was suggested that routine cervical pap smears were of great value as a screening method for all patients, as had been stressed by previous authors. It should not be used as definitive diagnosis but many early preclinical carcinomas can be detected if this procedure is used as a part of routine pelvic evaluation.

Horton, Bennett F., M.D.; Thompson, Robert B., M.D.; Dozy, Andree M., B.S.; Nechtman, Carl M., B.S.; Nichols, Evan, M.S., and Huisman Titus H. J., B.S., Ph.D., Medical College of Georgia, Augusta, Georgia, "Inhomogeneity of Hemoglobin VI, the Minor Hemoglobin Components of Cord Blood 20:302-313 (Sept.) 62.

During electrophoretic studies of cord blood hemoglobins, varying amounts of Hb-Bart's (Y_4) and Hb-H (B_4) were noted in many of over 300 cases. Fifty-four cases were studied more intensively. By special chromatographic techniques these components were isolated for quantitation and for special studies to establish their identity and characteristics.

It was found that concomitantly with a fall in the Hb-F there is a rise in Hb-A₂, a fall in the total quantity of Hb-Bart's plus Hb-H, when these are present, and a rise in the hemoglobin H: hemoglobin Bart's ratio. The Hb-Bart's and Hb-H did not persist beyond infancy and there was no evidence for any genetic abnormality to account for these findings. These results indicate that a slight "a-chain deficiency" is a common feature in the human fetus and also support the hypothesis of an identical genetic control of the synthesis of a-chains of Hb-F and Hb-A.

A hemoglobin thought to be Hb-Gower-II was found in the cord blood of a white premature baby.

Oxygen dissociation studies of Hb-Bart's revealed it to have a very high oxygen affinity, greatly reduced heme-heme interaction and the absence of a Bohr effect.

CURRENT AMA FILM CATALOG NOW AVAILABLE

The 1962 edition of the AMA Medical Health Film Library catalog is now available for distribution by the Medical Motion Pictures and Television Section of the Department of Scientific Assembly. This expanded catalog contains information about 173 films for professional audiences and 82 films to be used by physicians in addressing lay groups such as PTA, church organizations, service clubs, etc. A description of the content of each film, running time, service charges, and instruc-

tions for ordering are included in this catalog. The services of the AMA film library are available to physicians, medical societies, hospitals, medical schools and other medical groups. Copies may be obtained, without charge, by addressing your request to the American Medical Association, Medical Motion Pictures and Television Section, Department of Scientific Assembly, 535 North Dearborn Street, Chicago 10, Illinois.



THE ASSOCIATION

DEATHS

WADE H. BORN, 86, for 55 years a practicing physician and surgeon in McRae, died in a local hospital August 24, 1962.

Dr. Born graduated from the University of Georgia and the Atlanta College of Physicians and Surgeons. He was a recipient of a certificate of distinction from the Medical Association of Georgia for 50 years of medical practice, and he had been surgeon for the Southern and Seaboard Railroads for 40 years. He pioneered in the development of dewberries and his farm, the world's largest of its kind, attracted wide attention.

He was named a director of the Merchants Bank in 1921, chairman of the Board of Directors of the Merchants and Citizens Bank in 1937, and first vice-president and chairman in 1945. Since 1941 he had served on the board of directors of the First Federal Savings and Loan Association. Dr. Born was a member of the Methodist Church at McRae.

Survivors include his wife, Ruby McElroy Born of Norcross; a niece, Mrs. Carrie B. Mallard, Atlanta; four nephews, A. J. McCoy, Jr., East Point; Dr. R. W. Dubose, Elkins, W. Va.; Wade Dubose, Richmond, Va.; and Edwin Dubose, Washington, D. C.

REESE W. BRADFORD, a former assistant superintendent of the Milledgeville State Hospital, died September 1, 1962, at his home near Gainesville. Serving as clinical director and as an assistant superintendent for 18 years, Dr. Bradford was on the staff of the Milledgeville State Hospital for 37 years before his retirement in 1959. After his retirement at Milledgeville, he served as a staff physician at the South Carolina State Hospital in Columbia.

Dr. Bradford attended the University of Georgia before receiving his medical degree from the Medical College of Georgia.

He is survived by his widow, Willie Dell Lynch Bradford of Augusta; two sons, Reese W. Bradford, Jr., Marietta, and Robert E. Bradford, Decatur; two daughters, Mrs. Julian Sharpe, Milledgeville, and Mrs. E. C. Bass, West Palm Beach, Fla.; one sister, Mrs. Mose Gordon, Commerce; and eight grandchildren.

SAM YOUNGBLOOD, JR., Savannah physician, died at his home August 13, 1962.

Dr. Youngblood received his medical degree from Emory University in 1940 and began practicing medicine in Savannah in 1947 after serving his internship, residency, and tour of duty in the service.

He was a member of the staffs of Candler, Memorial, and St. Joseph's Hospitals in Savannah, of Sigma Chi Social Fraternity and Theta Kappa Psi Medical Fraternity, and of the Wesley Monumental Methodist Church. Dr. Youngblood was awarded a certificate of membership in the American Academy of General Medicine in 1955.

SOCIETIES

FRANKLIN-HART-ELBERT SOCIETY met September 5, 1962, at Elberton. Dr. R. H. Randolph of Athens presented a discussion on "Diseases of the Biliary Tract, Their Management and Diagnosis."

PERSONALS

First District

No news submitted.

Second District

No news submitted.

Third District

No news submitted.

Fourth District

DOUG HEAD, JR., of Thomaston, was presented a silver service as winner of the Sunset Hills Golf Tournament held August 18 and 19 at Carrollton.

Fifth District

Chief of the Communicable Disease Center at Atlanta since 1959, C. A. SMITH, Atlanta, has been named associate chief of the bureau of state services for community health activities in Washington. Dr. Smith assumed his new position September 1.

RICHARD KING, Atlanta thoracic surgeon, spoke to the members of the Madison Kiwanis Club August 14, 1962. Dr. King's topic was "Heart Surgery."

Lecturing to the Jacksonville Medical Educational Program recently in Jacksonville, Florida, was BRUCE LOGUE, Atlanta.

Ponce de Leon Infirmary announces the association of MARTON MAJOROS, formerly of the Mayo Clinic, as a member of the staff of ENT.

Sixth District

"The Problems of the Alcoholic," was the topic of a talk given to the County Medical Society at Columbia, S. C., August 13, 1962, by I. H. MacKINNON, Superintendent of Milledgeville State Hospital.

ZEB BURRELL, Milledgeville, was presented the Bronze Meritorious Service Medallion of the Georgia Heart Association at the Milledgeville Rotary Club meeting held August 23, 1962, at Milledgeville. GOOD-LOE ERWIN of Athens presented the award to Dr. Burrell in recognition of the contributions he has made in the fight against heart disease. Dr. Burrell has headed the group which organized the stroke clinic in Baldwin County, and has extended his work by assisting in organizing such clinics in other communities.

Seventh District

THOMAS EDWIN CUMMINGS, Rockmart, in August became the Goodyear Tire and Rubber Company's new plant physician. Dr. Cummings is succeeding the man who delivered him and for whom he is named, THOMAS EDWIN McBRYDE of Rockmart, who died in July after serving the plant since its opening in 1929.

Eighth District

Waycross pediatrician, VILDA SHUMAN, flew to Europe August 12, 1962, to attend the Tenth International Congress of Pediatrics September 10-17, in Lisbon, Portugal. While in Europe before attending the congress, Dr. Shuman toured France, Spain, Germany, Switzerland, and Italy.

Ninth District

At the August 2, 1962, meeting of the Lawrenceville Kiwanis Club, D. C. KELLEY, Lawrenceville physician, received special recognition and a certificate and a service pin for serving for 20 years as medical advisor of the local draft board.

"The Heart," and an explanation of its function, symptoms of heart attacks, and the importance of taking care of the heart, was the subject of a talk given to the Buford Kiwanis Club by STERLING HARRIS, Buford, at their meeting held August 7, 1962.

Tenth District

E. V. HASTING and JAMES W. MITCHENER, Augusta pathologists, are now providing pathology service and consultation at the Sandersville Memorial Hospital. The doctors visit the hospital each week and serve hospitals in Augusta, Washington, and Aiken, S. C., as well.

LEO J. WADE is now associated with L. KENDRICK LEWIS, Madison, in the practice of medicine.

Appointed Richmond County coroner's physician August 1, 1962, was IRVINE PHINIZY, Augusta.

W. A. THRELKELD, JR., has opened his office in Thomson for the practice of medicine.

EXECUTIVE COMMITTEE OF COUNCIL OF THE MEDICAL ASSOCIATION OF GEORGIA AND EXECUTIVE COMMITTEE OF THE STATE BOARD OF PUBLIC HEALTH

THE MEETING of the Executive Committee of Council of the Medical Association of Georgia and the Executive Committee of the State Board of Public Health was called to order by the President of the Medical Association of Georgia, Thomas W. Goodwin, at 7:05 P.M., August 18, 1962, MAG Headquarters Building, Atlanta, Georgia.

The members of the MAG Executive Committee in attendance were: Thomas W. Goodwin, Augusta; George H. Alexander, Forsyth; Fred H. Simonton, Chickamauga; John T. Mauldin, Atlanta; J. G. McDaniel, Atlanta; Lee H. Battle, Rome; and John S. Atwater, Atlanta. Representing the Executive Com-

mittee of the State Board of Health were: Miller Byne, Waynesboro; Bernard C. Holland, Atlanta; Sterling Claiborne, Atlanta; and Fred H. Simonton, Chickamauga. Representing the State Department of Public Health were: John Venable, Atlanta; and S. C. Rutland, Atlanta, MAG Staff members, present were Mr. Milton D. Krueger, Mr. James M. Moffett and Mrs. Catherine Wooten.

President Goodwin asked Dr. Venable to review the Proposed Bill to Revise the Codification of Laws Relating to Public Health. There was general discussion regarding the wording of certain provisions in the bill, but no agreement was reached on the rewording.

When asked by President Goodwin about the Family Responsibility Proposal, which is not included in this bill, Dr. Venable replied that the State Department of Public Health was instructed to submit the Family Responsibility Proposal as a separate bill. Following this there was discussion pro and con regarding this item. President Goodwin asked Dr. Venable and members of the Executive Committee of the State Board of Public Health to keep the MAG Executive Committee informed of any future actions taken on the recodification bill and on the Family Responsibility Proposal, before it is submitted to the Legislature.

There being no further business the meeting was adjourned at 9:45 P.M.

EXECUTIVE COMMITTEE OF COUNCIL

THE AUGUST MEETING of the Executive Committee of Council was called to order at 10:10 A.M. August 19, 1962, MAG Headquarters Building, Atlanta, Georgia, by President Thomas W. Goodwin.

Executive Committee members present were: Thomas W. Goodwin, Augusta; George H. Alexander, Forsyth; Fred H. Simonton, Chickamauga; John T. Mauldin, Atlanta; J. G. McDaniel, Atlanta; Lee H. Battle, Rome; and John S. Atwater, Atlanta. Others present were: Virgil Williams, Griffin; Peter Hydrick, College Park; Mr. James Baker, Medicare Administrator; and Mr. O. P. Ensign, of Waddell and Reed, Inc., Atlanta. MAG Staff members present were Mr. Milton D. Krueger, Mr. James M. Moffett and Mrs. Catherine Wooten.

The minutes of the July 18, 1962, Executive Committee meeting were reviewed by Mr. Krueger, and were approved as read.

Treasurer's Report

Dr. Atwater gave the Treasurer's Report. On motion duly made and seconded it was voted to approve the adoption of the Treasurer's Report as presented.

Medicare Problems

Mr. James Baker discussed: (1) Dr. Mercer's claim, the settlement of which had been recommended at the July Executive Committee meeting, and with which he is still dissatisfied;

(2) The practicing of a South Carolina physician practicing in Hartwell, Georgia, without a Georgia license, and who had made a claim to Medicare for services rendered in Hartwell. Executive Committee recommended that Mr. Baker and Dr. Mauldin investigate the possibility of changing the Medicare contract, if necessary, to pay claims of out-of-state doctors;

(3) The meeting of the State Medicare Review Board on September 30, 1962, was announced.

MAG Employees Pension Plan

Dr. McDaniel gave information on the proposed establishment of a pension plan for the Executive Employees of the MAG. Mr. Ensign, representing the United Funds, Incorporated, explained some of the details. After discussion, on motion (Alexander-Atwater) it was voted that the Executive Committee approves the pension plan in principle with the recommendation that this plan be presented to Council at the September meeting with an estimate of the legal fee involved in drawing this plan and rendering an opinion regarding the tax status of the recipients at the time of retirement.

Disaster Medical Care Sub-Committee Project

Virgil Williams, Chairman of the Disaster Medical Care Sub-Committee, requested approval and asked permission to

insert a pamphlet on the Civil Defense Emergency Hospital in the next issue of the *JMAG* as a Supplement. On motion (Mauldin-Simonton) it was voted to approve the insertion of the pamphlet in the *JMAG*. Dr. Williams read a letter regarding a Highway Safety Program Luncheon, which he did not feel he should attend. He was asked to mail this to Darius Flinchum, Atlanta, who is a member of the Sub-Committee on Public Service.

MAG 1963 Annual Session Program

Peter Hydrick, Chairman of the Annual Session Board, discussed the 1963 Annual Session Floor Plan and Scientific program. On motion duly made and seconded it was voted to approve the program and floor plan as presented.

Interim Legislative Committee on Public Health Code Appointment

President Goodwin asked for suggestions for the appointment of someone to act as liaison with the Interim Legislative Committee to review the proposed public health code, and also asked for discussion regarding the attitude of MAG on the recodification. It was recommended that the AMA Legal Department be asked to render an opinion regarding the payment of physicians' fees in the family Responsibility Proposal. The Executive Committee approved this recommendation. On the subject of recodification the following motion (Simonton-Alexander) was approved: (1) that the Director of the State Department of Public Health not be under the Merit System; (2) that the full Board meet once a month; (3) that MAG take a renewed interest in subsequent nominations to the Board, and; (4) that 88-112 of the Code be amended to read "subject to the approval of the State Board of Health." The Executive Committee recommended that the above changes be submitted for Council approval.

The appointment of a liaison member with the Interim Legislative Committee, as mentioned above, was discussed. President Goodwin agreed to act in this capacity on a temporary basis. Secretary Mauldin was instructed to write Dr. Venable regarding this appointment.

Board of Medical Examiners Joint Meeting with MAG Executive Committee

Secretary Mauldin suggested that a joint meeting be held with the State Board of Medical Examiners. On motion duly made and seconded it was voted to approve the setting up of a joint meeting between the MAG Executive Committee and the State Board of Medical Examiners for the discussion of mutual problems.

Professional Liability Committee Appointment

On motion duly made and seconded it was voted to appoint Secretary Mauldin to act in this capacity this year with Dr. Charles Jones' assistance, and a third man to be selected by Drs. Mauldin, Atwater and McDaniel, to take this position next year.

MAG ATTORNEY'S ESTIMATED FEES

Dr. Mauldin read the letter from the MAG Attorney confirming estimates of fees discussed at the July Executive Committee meeting by Mr. Moore, in connection with Porter vs. Patterson; Bell vs. MAG; and Fulton County and City taxes.

AMA Congress on Mental Health

Mr. Krueger stated that the Chairman of the Sub-Committee on Mental Health, Dr. Maurice Arnold, had been contacted regarding the attendance at the AMA Congress on Mental Health to be held in Chicago October 4-6, 1962, and that he did not wish to attend. A request from AMA had been made for MAG to send a representative. After some discussion it was decided that the request should be answered at a later date when a decision is made.

Welfare Contract Expansion

Dr. Mauldin explained the suggested expansion of the Kerr-Mills Program in Georgia to become effective September 1, 1962, and asked approval of the Executive Committee. On motion (McDaniel-Alexander) it was voted to approve the suggested expansion as presented. The new contract between the MAG and the State Department of Public Welfare was approved as follows:

"RESOLVED, that Executive Committee of Council of the

Medical Association of Georgia approves the Contract with the State Department of Public Welfare to be effective September 1, 1962, attached to these Minutes and made a part hereof, and authorizes and directs the officers of the Association to execute and attest the said Contract on its behalf, and to agree to and make any further changes in wording as may be required in said Contract;

"RESOLVED FURTHER, that the execution of the Contract with the State Department of Public Welfare by the President or First Vice-President of the Association, and attested by its Secretary, shall be conclusive evidence of this Executive Committee's approval of the terms of said Contract."

"RESOLVED, that John T. Mauldin, M.D., be and is hereby designated as the Medical Director of the Medical Care for Adult Program Recipient.

This 19th day of August, 1962.

Professional Conduct Case

Mr. Moffett reported that from information received the physician involved had left the state. Mr. Moffett had been asked to render a report on this case per the July Executive Committee meeting minutes. Report received for information.

Headquarters Office Report

Mr. Krueger stated he had no report other than to request additional funds for personnel employment, if necessary. On motion duly made and seconded it was voted to recommend to Council that they authorize additional funds for such purpose.

Old Business

(a) Committee to Study Adoption Practices Appointment: Peter Hydrick, College Park, was appointed to this committee. Secretary Mauldin was instructed to inform Dr. Hydrick of this appointment.

(b) Tax Case Concerning Deductibility of Automobile Expenses: After further discussion on the subject of a case, which has been discussed at previous Executive Committee meetings, it was voted that no further action be taken as no funds are available.

(c) Salk Institute Building Fund Letter: This letter asking for contributions to the Salk Institute Building Fund was received for information.

(d) Booth at Southeastern Fair for Distribution of Health Care Program Literature: Dr. Atwater had received a request to set up a booth for the distribution of Health Care Program literature. It was suggested that if the Fulton County Medical Society had a booth, the literature could be distributed by them, if they cared to do so.

(e) State Medical Education Board: Dr. Simonton reported on the State Medical Education Board activities.

(f) Georgia Nutrition Council Letter: Dr. Goodwin read a letter from the Georgia Nutrition Council requesting cooperation in planning and carrying out a program of health and physical fitness of the youth in Georgia and the nation. This letter was received as information.

(g) AMA House of Delegates Resolutions: The AMA Council on Medical Service has asked for information concerning "planning" committees of MAG to carry out directives of the AMA House of Delegates regarding "Medical Care Commission," "Establishment of Continuing Commission (or Council) on Health Care of the Nation," and "Creation of Commission to Study Problems of Patient Care, Medical Practice, Hospital Service, and Medical Education." It was recommended that this item be placed on the September Executive Committee meeting agenda.

(h) Date and Site of September Executive Committee meeting: It was decided to hold the meeting immediately following the September 9 Council meeting at Jekyll Island.

There being no further business the meeting was adjourned at 2:45 P.M.

EXECUTIVE COMMITTEE OF COUNCIL

THE EXECUTIVE COMMITTEE of Council was called to order at 11:10 A.M., September 9, 1962, Buccaneer Motor Lodge, Jekyll Island, Georgia, by the President Thomas W. Goodwin.

The members attending were: Thomas W. Goodwin, Augusta; George H. Alexander, Forsyth; George R. Dillingcr, Thomasville; John T. Mauldin, Atlanta; J. G. McDaniel, Atlanta; and Fred H. Simonton, Chickamauga. Also present were Joseph B. Mercer, Brunswick; Mr. Richard Nelson, AMA Field Repre-

senative; Mr. John Moore, MAG Attorney; Mr. James Baker, Medicare Administrator; and Mr. Milton D. Krueger, Mr. James M. Moffett and Mrs. Catherine Wooten, of the MAG Staff.

Reading of Minutes

The minutes of the Executive Committee meeting August 19, 1962, were reviewed at the Council meeting just adjourned and the Chairman did not think it necessary to read these again.

AMA House of Delegates Resolutions

President Goodwin stated that a letter from the AMA regarding certain House of Delegates Resolutions had been received and asked the Executive Committee what disposition they desired on this item. On motion duly made and seconded it was voted that the Secretary be instructed to answer the AMA letter.

Medicare Claim

A claim previously discussed at the July and August Executive Committee was reconsidered. After much discussion on the aforementioned case, on motion (Dillinger-Mauldin) it was voted that the Medicare office in Washington be written that after a hearing with the physician, at which time certain information regarding his fee and other data pertaining to the case, was made available that was not available before the hearing, the Executive Committee recommends that the full claim be paid. It was recommended that a letter be written to the physician of this Executive Committee action and it was also recommended that the Medicare Administrator write another physician that the Medicare office did not receive his letter of complaint, and that upon receipt of his reply Executive Committee would make an effort to reconsider his claim.

New Business

(a) Date and Site of October Executive Committee meeting: October 7, 1962, MAG Headquarters, Atlanta. Secretary Mauldin was asked to try to schedule a meeting with the State Board of Medical Examiners in the morning of October 7, and the Executive Committee to meet in the afternoon.

There being no further business the meeting was adjourned at 11:55 A.M.

MEDICAL ASSOCIATION OF GEORGIA COUNCIL

THE MEETING OF THE COUNCIL of the Medical Association of Georgia was called to order by the Chairman George H. Alexander on September 8, 1962, at 2:05 P.M., at the Buccaneer Motor Lodge, Jekyll Island, Georgia.

Members of Council attending were: George H. Alexander, Forsyth; Thomas W. Goodwin, Augusta; George R. Dillinger, Thomasville; Fred H. Simonton, Chickamauga; Walker L. Curtis, College Park; John T. Mauldin, Atlanta; J. Frank Walker, Atlanta; Joseph B. Mercer, Brunswick; Edgar Woody, Jr., Atlanta; Charles Bohler, Brooklet; W. Frank McKemie, Albany; Frank Wilson, Leslie; Virgil Williams, Griffin; Floyd Sanders, Decatur; William Rawlings, Sandersville; C. R. Andrews, Canton; Addison Simpson, Jr., Washington; Walter Brown, Savannah; H. D. Pinson, Augusta; W. P. Jordan, Columbus; J. G. McDaniel, Atlanta; J. C. Brim, Pelham; C. T. Cowart, LaGrange; John Bell, Dublin; J. L. Mulherin, Augusta; and Henry H. Tift, Macon. Also present were C. S. Britt, Brunswick; Mr. John Moore, MAG Attorney; Mr. Richard Nelson, AMA Field Representative; Mr. James Baker, Medicare Administrator; and Mr. Milton D. Krueger, Mr. James M. Moffett and Mrs. Catherine Wooten, of the MAG Staff.

The invocation was given by Dr. Alexander.

Reading of Minutes

Mr. Krueger reviewed the minutes of the Council meeting of June 16-17, 1962, and the Executive Committee meetings of June 16, July 2 and 18, August 18-19, 1962, and all were approved as read.

Proposed Special Called Session of MAG House of Delegates

Past President Simonton proposed a Special Called Session

of the MAG House of Delegates in October with an invitation to the elected candidates, Congressmen and Senators, State House Representatives, and allied medical persons, to discuss the health care problems in Georgia, to inform them of our position, and to ask cooperation of all in a concerted effort. Dr. Simonton asked Council members to consider his suggestion and discuss this subject at the September 9th meeting.

Treasurer's Report

Mr. Krueger made the Treasurer's Report in the absence of Dr. Atwater. On motion duly made and seconded the report was approved as read.

Executive Committee Recommendations on Proposed Bill to Review Codification of Public Health Laws

President Goodwin discussed the "Proposed Bill to Revise the Codification of the Public Health Laws" and the "Family Responsibility Proposal." On the subject of recodification Mr. Goodwin read the four recommended changes made by Executive Committee at the August 19 meeting as follows: (1) that the Director of the State Department of Public Health not be under the Merit System; (2) that the full Board meet once a month; (3) that MAG take a renewed interest in subsequent nominations to the Board; and (4) that 88-112 of the Code be amended to read "subject to the approval of the State Board of Health." After general discussion on motion duly made and seconded it was voted to accept the recommendations of the Executive Committee, as stated above, regarding the codification of the Public Health Laws. On further motion duly made and seconded it was voted that Council empowers the Executive Committee of Council, in between meetings of Council, to formulate and evaluate other changes and to express the position of MAG on any such changes of the Health Code which seems proper to it.

With regard to the "Family Responsibility Proposal," Dr. Goodwin stated that the AMA Legal Department has been asked to render an opinion and this would be presented at the December Council meeting. After discussion on this subject, on motion duly made and seconded, it was voted that Council goes on record as supporting the general idea of the Family Responsibility principle, but opposes any form of it which would constitute the practice of medicine by the State of Georgia.

MAG 1962 Annual Session

Mr. Krueger gave a report for Dr. Hydrick, who could not be present, on: (1) The Scientific Program for the Annual Session. On motion duly made and seconded the program was approved as presented. (2) Hotel and Motel Room Space: The Glynn County Local Arrangements Chairman assured the Council that an adequate number of rooms would be available to accommodate those attending the Annual Session. (2) Headquarters Motel: After some discussion on motion it was voted to retain the Buccaneer Motor Lodge as Headquarters Hotel for the Annual Session.

September 1, 1962, Expansion of Kerr-Mills Program

Dr. Mauldin discussed the September 1 expansion of the Kerr-Mills Program in Georgia and stated that the contract was approved. This information was given as a progress report.

National and State Legislative Report

J. Frank Walker, Chairman of the National Legislative Subcommittee, spoke on the HR 11581, which will place a burden on the drug advertisers in the *JMAG*. Mr. Nelson commented on the AMA position, and also discussed HR 10 (Jenkins-Keough Bill) status. The State Legislative Subcommittee report was given by Mr. James M. Moffett.

Report on AMA Annual Meeting, Chicago, June 24-28, 1962

AMA Delegate Henry H. Tift gave a report on the AMA meeting in Chicago and mentioned the new McCormick Place exhibit hall. Dr. Tift recommended that beginning January 1, 1963, J. W. Chambers be designated Chairman of the AMA delegation and on motion (Tift-McDaniel) Council approved this recommendation.

City-County Ad Valorem Taxes and Civil Court Case

Secretary Mauldin read a letter from the MAG attorney regarding estimated charges for handling the Civil Court Case and the litigation regarding the City-County tax matter. Mr. John Moore reported on the status of the two cases in question.

Estimates on Installation of Stove and Sink in MAG Headquarters Building

Mr. Krueger presented two bids for Council consideration: (1) \$879.00; (2) \$895.00 or \$859.00; depending on size of stove. After discussion as to the merits of each, on motion (McDaniel-Bell) it was voted to accept the (2) bid of \$895.00, with the funds to be taken out of the Contingent Fund.

This portion of the Council meeting was recessed at 5:00 P.M.

The September Council meeting was reconvened at 8:15 A.M. on September 9, 1962.

MAG Employees Pension Plan

Dr. McDaniel, Chairman of the Finance Committee, asked that this item be deferred until the December Council meeting.

Eugenic Sterilization

Mr. Moffett stated that the Maternal and Infant Welfare Sub-Committee would make a report on Eugenic Sterilization at the December Council meeting.

1962 MAG House of Delegates Actions Review

Speaker J. Frank Walker reported on the progress of the House of Delegates actions. One action is required of Council that they appoint a committee to work with the Health Insurance Council in promoting greater liaison between physicians, insurance companies and medical societies in the State of Georgia. On motion duly made and seconded it was voted that the President be authorized to appoint a committee as instructed by the House of Delegates. President Goodwin asked Secretary Mauldin to assist with the appointment of this committee.

Headquarters Office Report

Mr. Krueger asked for Council approval of additional funds for personnel. On motion duly made and seconded it was voted to appropriate \$200.00 from the Contingent Fund for such for the remainder of this year.

Mr. Krueger reported on the AMA Institute in Chicago, August 30-31, 1962. He mentioned certain ideas received at this meeting which would be helpful in planning the County Medical Society Officers Conference for 1963.

Unfinished Business

(1) AMA National Congress on Mental Health—President Goodwin stated that many MAG members had requested that an official representative be designated to attend this meeting. On motion duly made and seconded it was voted that August S. Yochem, Atlanta, be designated as the MAG representative to this meeting and that he be requested to make a report afterward to Council.

(2) *JMAG* Editor Edgar Woody asked Council's opinion regarding the publication of a map in the *Journal* which would designate physician public speaking activity over the state. Council approved this idea. Dr. Woody also stated that national advertising had not increased. He also mentioned that the specialty listings in the MAG Roster were somewhat obsolete and that he intended to put an insertion in the 1963 *Journal* Roster for the purpose of obtaining more recent information.

(3) Medicare Problem—Dr. Mercer discussed the Medicare program in Georgia in general and expressed dissatisfaction with certain phases of the program. He proposed that the State Medicare Review Board be directed by Council that:

- (1) All previous "ground rules" be wiped out;
- (2) New regulations be set up;
- (3) Exact recourse be outlined and publicized to physicians;
- (4) State officers conduct themselves as impartial administrators and see that no abuses be allowed, but that the method of changing regulations be specifically outlined and no arbitrary action taken;
- (5) Executive Committee should have all changes presented to it and be specifically approved by the Executive Committee;

- (6) All minutes of State Medicare Review Board meetings be kept so each subsequent Administrator can know of previous actions.

On motion (Mercer-McDaniel) it was voted to direct the State Medicare Review Board as stated above.

New Business

(1) Explorer Boy Scout Specialty Program: Dr. Walker Curtis discussed the Explorer Specialty Program in the medical field, which seeks technical advice to form an allied medical careers group from the Explorer Scouts. The following Resolution was approved by Council:

"WHEREAS the need for youth to understand and appreciate the Free Enterprise system is apparent to all thinking Americans, and

"WHEREAS there is great need for able young men to prepare for and enter the Medical Profession, and

"WHEREAS there is a greater need in America for Citizenship Training, and

"WHEREAS the Scouting Movement through its Explorer Program for boys 14 through 18 offers the following opportunities for bringing these objectives to us through Specialty Posts majoring in the Medical Field, and

"THEREFORE, BE IT RESOLVED that we, the MEDICAL ASSOCIATION OF GEORGIA, adopt this program in principle and that we recommend to our local Societies the organization and utilization of this program by organizing Specialty Posts in the field of Medicine with the aid of the local Scout Officials in their respective areas."

(2) State Disciplinary Board—Dr. Charles Bohler, Brooklet, read a letter from Bulloch-Candler-Evans County Medical Society asking that the Council take cognizance of the legal powers of the State Board of Medical Examiners.

(3) Facilities of V.A. Hospital in Atlanta—Mr. Krueger read a letter from Lester Rumble, Atlanta, regarding the lack of certain facilities at a new V.A. Hospital to be built in Atlanta, such as an intensive care area. On motion duly made and seconded it was voted that Council approves Dr. Rumble's recommendation, but first directs that this matter be referred to the MAG Hospital Relations Sub-Committee, in advice with Dr. Rumble, to investigate the matter and if the situation is true, to continue as recommended above.

(4) County Medical Society Request—R. E. Jennings, Arlington, Secretary of the Southwest Georgia County Medical Society, requested by telephone an opinion regarding several physicians, whose practice is predominantly in Randolph-Terrell County Medical Society area, and who believe they could get more Medical Association benefit from joining the Southwest Georgia Medical Society because they state the Randolph-Terrell Society is inactive. On motion (McDaniel-Brown) it was voted that the Councilors of the two areas involved should investigate the possibility of combining the two county medical societies or reactivating the inactive society. It was recommended that a letter stating this action should be written to Dr. Jennings and to the two Councilors.

(5) Laurens County Medical Society Problem—Mr. Krueger gave Council information regarding a letter received from a patient at the Laurens County Hospital. On motion (McKemie-Bell) it was voted that the President should write the patient but that the MAG attorney should review the letter before it is mailed.

(6) Shrine Hospital in Upson County: Dr. Sam E. Patton, Macon, requested a letter stating that the MAG would welcome a Shrine Hospital for Burned Children in Georgia. On motion (Mauldin-Dillinger) it was voted to approve the hospital being built in Georgia, but with the recommendation that the Shrine organization work with the MAG Hospital Relations Sub-Committee as to location.

(7) Olliff Letter: A letter from Mrs. Henry H. Olliff was read thanking MAG for the Life Membership card sent to her, as Dr. Olliff is deceased.

THE ASSOCIATION / *Continued*

(8) Coolidge Letter: A letter from Mr. H. B. Coolidge, Savannah, thanking MAG for the Certificate of Appreciation given him at the 1962 MAG Annual Session, was read.

(9) JMAG Supplement: A letter from Dr. Lester M. Petrie regarding the "Medical Aid to Georgians in Disaster" leaflet was read. This leaflet will be mailed as a Supplement to the October issue of the JMAG.

(10) American Association of Medical Assistants: A letter from the AAMA was read thanking MAG for assistance given this organization.

(11) GaMPAC Program: Dr. Mercer reported on the membership program planned at the meeting held on September 8, 1962.

(12) Date and Site of December Meeting: Dr. McKemie extended an invitation to Council to meet in Albany on December 8-9, 1962. On motion duly made and seconded it was voted to accept Dr. McKemie's invitation.

(13) Special Called Session of House of Delegates: Past President Simonton asked Council's opinion on his request of yesterday. On motion (Goodwin-Mauldin) it was voted to ask Executive Committee to investigate the possibilities of this recommendation.

(14) Glynn County Medical Society and Vice Speaker of House Letters of Thanks: It was voted to write letters of appreciation to Glynn County Medical Society President C. S. Britt and Vice Speaker of the House Joseph Mercer, who acted as hosts for this Council meeting.

There being no further business the meeting was adjourned at 11:05 A.M.

GEORGIA BECOMES MEMBER OF AMERICAN ASSOCIATION OF BLOOD BANKS

Dr. Jack C. Norris, Chairman of the Sub-Committee on Blood Banks, has been informed that the Medical Association of Georgia's application for membership in the American Association of Blood Banks was approved on September 5, 1962. This membership bestowed represents the first one in the United States in which a state has been so accepted. Heretofore, all memberships have gone to individuals who were interested in blood banking, and not to groups. Georgians have good reason, therefore, to feel highly honored.

The American Association of Blood Banks is headquartered at Chicago. Dr. Frank E. Trobaugh, Jr., Secretary and his staff attend to the Association's extended problems in this field of medicine. The purpose of this group is highly significant and far reaching in its activity. It is broadly set to, "conduct, maintain, and support benevolent undertakings by making available through blood banks whole blood or its derivatives for the alleviation of human pain and suffering and the saving of human lives." This represents the highest ideals of medicine. In addition to the above, there are other activities, but as a state group, one very important project will be, "to encourage the development of blood banks through education, public information, and research, and to enable the committees to better prepare blood banks at times of disaster."

The Sub-Committee of Blood Banks in Georgia will gradually develop a very strong program for the future, largely guided in this by the American Association of Blood Banks. In addition, the committees expect to consider seriously the promotion of a Blood Bank Department under the State Board of Health in order that small hospitals and clinics in the state can have substantial supervisory help.

Serving on this committee with Dr. Norris are Dr. Walter Shephard of Augusta, and Dr. Irving L. Greenberg, Atlanta.

NEW HEALTH CARE BILL ADOPTED BY WAYS AND MEANS COMMITTEE

In a surprise move the House Ways and Means Committee voted unanimously to adopt a bill providing tax incentives to employers who would include health care benefits in their employee retirement programs.

The bill, H.R. 10117, authored by Congressman Thomas B. Curtis of Missouri, himself a member of the tax writing Committee, was introduced as an alternative to the King Bill last February. The fact that it received unanimous endorsement by the Ways and Means Committee has been interpreted to imply wide spread support in the House of Representatives.

Under existing law, employing companies may claim a tax deduction on all money contributed toward employee retirement plans. However, if medical expenses are included, the entire tax deduction is lost to the employer. Because of the tax penalty under current law, industry has avoided adding medical expenses to its retirement plans.

Approximately 15 million employees are currently covered by pension funds valued at approximately \$50 billion. As adopted by the Ways and Means Committee, H.R. 10117 would permit medical benefits for retirees, their spouses and dependents to be added to retirement programs without a tax penalty to the employer.

At this writing no tentative target date has been set for the adjournment of the 87th Congress. The middle of September has been suggested as the most likely time. Should this be the case, Congress will have to move rapidly in order for this bill to be enacted prior to adjournment. Should this bill not be enacted this year, it must then be reintroduced and sent to the Committee on Ways and Means for approval or rejection next year.

Passage of this bill would go a long way toward taking the steam out of Administration insistence on passage of Social Security based health care legislation.

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ASIAN INFLUENZA THREATENS AGAIN

See Page 545

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TREATMENT OF DIABETES MELLITUS

William K. Jenson, M.D., *Philadelphia, Pennsylvania*

- ***Practical suggestions are made relative to the management of patients with this metabolic defect.***

DIABETES MELLITUS IS A CHRONIC LIFE LONG disease for which there is no known cure. It is due to an absolute or relative lack of endogenous insulin activity. The basis of any therapy must be either to reduce the demand for insulin, as in the obese diabetic patient, or to supply insulin exogenously by injection or endogenously by oral hypoglycemic agents. In addition, as in any chronic disease, the physician must help the patient to adjust to his disease. The patient and his family must be reassured that diabetes is not a death sentence, that with cooperation, proper control may be obtained with regulation of diet, activity and insulin or hypoglycemic agent if indicated. Detailed instruction and counseling will pay dividends in better and smoother control.

Diagnosis

Symptomatic diabetes, polyphagia, polyuria and polydipsia, leave little doubt as to the diagnosis. The finding of glycosuria and hyperglycemia is confirmatory. The diagnosis in adults, as in children, with an abrupt onset of the disease accompanied by the classical symptoms, constitutes a minority of the diabetic population. Diabetes may be asymptomatic in adults and a high index of suspicion is needed in order to diagnose the disease in the earliest stages. The diagnosis of diabetes must be suspected in any

relative of a diabetic, obese person, presence of unexplained weight loss, pruritis, visual disturbances, myocardial infarction in the young male or premenopausal female, or delivery of a premature infant or one weighing in excess of nine pounds.

Laboratory diagnosis of diabetes depends on the finding of hyperglycemia. Criteria for a normal blood sugar may vary according to the method of determination. The Folin and Wu and the Somogyi-Nelson methods are widely used. The values obtained by the latter method are believed to measure "true blood glucose" by eliminating certain non-glucose reducing substances and are therefore about 20 mgm per 100 cc lower than values by the Folin and Wu method. Subsequent blood sugar values are by Somogyi-Nelson method.

In individuals exhibiting none of the manifestations of diabetes, but in whom the diagnosis is suspected, a specimen of blood taken two hours after a liberal meal or following the ingestion of 100 Gm. glucose may be diagnostic of diabetes if above 120 mg. per 100 cc. Because the mild diabetic often has a normal fasting blood sugar value, the two hour post-prandial blood sugar value is more likely to be positive when used as a screening test. A value between 110 and 120 mg. per 100 cc would indicate "probable diabetes."

Glucose tolerance tests are indicated when the diagnosis of diabetes cannot be confirmed or ruled out without them. For at least three days prior to the test the diet should contain 300 Gm. carbo-

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Instructor in Medicine, University of Pennsylvania.
Presented at the 108th Annual Session of the Medical Association of Georgia, May 7, 1962, Savannah, Georgia.

hydrate plus maintenance calories in order to ensure the reproducibility of the test. Glucose, 1.75 Gm/kg ideal body weight, is administered orally after obtaining a fasting blood sugar sample. Normal glucose tolerance would be indicated by values below 110 mg. per 100 cc at two hours and a peak value below 160 mg. per 100 cc. Findings of a peak value above 160 mg. per 100 cc and a two hour value above 120 mg. per 100 cc would be diagnostic of diabetes. Borderline values are clarified by finding a one and one-half hour value 140 mg. per 100 cc or more. "Probable diabetes" is present when the peak value at one hour is 160 mg. per 100 cc or above, the one and one-half hour value 135 mg. per 100 cc or above, and the two hour value is between 110 and 120 mg. per 100 cc.¹

Dietary Treatment

Diet remains the foundation of therapy to which other forms of treatment may be added. The calculation of a suitable diet for the individual should not be difficult, realizing that this is an estimation of the caloric requirement of the individual and only subsequent visits and weighings will determine its adequacy. Caloric allowances are calculated on the basis of age, height, sex and physical activity. Determine the desirable weight for the patient from Table I. The number of basal calories required is obtained by multiplying the desirable weight by a factor of ten. If the patient is short, female or elderly subtract 100 to 200 calories, if the patient is tall, male or young add 100 to 200 calories.² If the patient is grossly overweight subtract 500 calories. Activity will necessitate additional calories; therefore, add 30 per cent additional calories for normal activity, 50 per cent for moderate activity and 75 per cent for physical labor.

Standard diets may be obtained from the American Diabetes Association. These diets utilize the exchange system of individual items in the menu and offer an easily adjustable dietary program.

Example: Young male 5 ft. 10 in. height, ideal weight 160 lbs.

Basic caloric requirement . . . 160 x 10 . . . 1600 cal.
Young, tall, male . . . add 200 calories . . . 200 cal.
Activity . . . add 50% (900 calories) . . . 900 cal.
2700 cal.

Insulin Therapy

Insulin therapy is indicated in all diabetic children, all underweight or thin adult diabetics whose diabetes is not under perfect control on a diet containing enough calories to correct the malnourished

TABLE I*

Desirable Weights for Men of Ages 25 and Over				
Height		Small Frame	Medium Frame	Large Frame
Feet	Inches			
5	2	112-120	118-129	126-141
5	3	115-123	121-133	129-144
5	4	118-126	124-136	132-148
5	5	121-129	127-139	135-152
5	6	124-133	130-143	138-156
5	7	128-137	134-147	142-161
5	8	132-141	138-152	147-166
5	9	136-145	142-156	151-170
5	10	140-150	146-160	155-174
5	11	144-154	150-165	159-179
6	0	148-158	154-170	164-184
6	1	152-162	158-175	168-189
6	2	156-167	162-180	173-194
6	3	160-171	167-185	178-199
6	4	164-175	172-190	182-204

Desirable Weights for Women of Ages 25 and Over				
4	10	92- 98	96-107	104-119
4	11	94-101	98-110	106-122
5	0	96-104	101-113	109-125
5	1	99-107	104-116	112-128
5	2	102-110	107-119	115-131
5	3	105-113	110-122	118-134
5	4	108-116	113-126	121-138
5	5	111-119	116-130	125-142
5	6	114-123	120-135	129-146
5	7	118-127	124-139	133-150
5	8	122-131	128-143	137-154
5	9	126-135	132-147	141-158
5	10	130-140	136-151	145-163
5	11	134-144	140-155	149-168
6	0	138-148	144-159	153-173

* Metropolitan Life Insurance Company, New York, N. Y.

state, in all pregnant diabetics, and in any diabetic, who during an acute complication exhibits hyperglycemia and glycosuria.

A clinical classification of diabetes is helpful in the choice of appropriate therapy in the individual diabetic patient. Table II illustrates such a classification.

Mild Diabetes (Overweight Adults)

The obese diabetic, in the absence of complications, does not need insulin. The diabetes is mild and often will be controlled with weight reduction alone. The grossly overweight diabetic in whom weight reduction will, of necessity, take place over a long period and in whom hyperglycemia and glycosuria is a consistent finding will usually do well with the addition of an oral hypoglycemic agent to control the hyperglycemia. Once the desirable weight for the individual is attained the glucose tolerance test reverts to normal. In the small percentage of patients in whom the tolerance for glucose remains abnormal an oral sulfonylurea hypoglycemic agent may be given.

Mild to Moderate Diabetes
(Adults — Normal or Subnormal in Weight)

The adult diabetic of normal or subnormal weight usually can be well controlled with one injection of

intermediate acting insulin administered one half to one hour before breakfast. NPH, Globin or Lente insulin in a dose range of 10-40 units is usually sufficient. A small percentage of this group need, if a forenoon hyperglycemia and glycosuria is to be avoided, a more rapidly acting insulin added to the intermediate acting insulin. A few patients in this group will respond to the oral hypoglycemic agents, but it is in this group that the largest percentage of primary and secondary failures on oral therapy are found, particularly if weight loss has been a feature of the diabetic state.

Labile (Severe) Diabetes (Juveniles and Adults)

In order to prevent wide swings in blood sugar and to control the hyperglycemic state throughout the twenty-four hour period it is usually necessary to employ a mixture of rapidly acting insulin and intermediate acting insulin one half hour before breakfast and a small dose of intermediate acting insulin after dinner or at bedtime. It has been possi-

TABLE II
CLINICAL CLASSIFICATION OF DIABETES WITH ILLUSTRATIVE THERAPY

(A) MILD DIABETES: (Overweight Adults)				
I. Reduction Diet—alone.				
OR: In selected cases, Oral hypoglycemic agents added.				
1. Tolbutamide (Orinase)				
2. Chloropropamide (Diabinese)				
3. Acetohexamide (Dymelor)				
4. Phenformin (DBI)				
(B) MILD TO MODERATE SEVERITY OF DIABETES: (Adults—weight normal or below normal in weight)				
I. Intermediate Acting Insulin.				
(1) NPH (2) Globin (3) Lente—(10 to 40 units)				
OR: If necessary.				
(1) Mixture of rapid and intermediate acting insulins.				
a. NPH + Crystalline or regular insulin (24 + 8)				
b. Lente + Semi Lente insulin (22 + 8)				
c. Globin + Crystalline or regular insulin (15 + 15)				
OR: Possibly: Oral Hypoglycemic Agents.				
(1) Tolbutamide, Chloropropamide or Acetohexamide.				
(2) Phenformin + Tolbutamide or Chloropropamide.				
(C) SEVERE (LABILE) DIABETES: (Juveniles and Adults)				
I. Mixture of short acting + intermediate acting insulin before breakfast and a small dose of intermediate acting insulin after dinner or at bedtime.				
(NPH + Crystalline and NPH) $\frac{32}{10}$ — 0 — 8				
OR: Mixture of short acting + long acting insulin before breakfast.				
(Semi Lente + Ultra Lente) 14 + 36				
OR: Possibly substitution of 50 - 100 mg. Phenform at bedtime for the small dose of intermediate acting insulin required at dinner or at bedtime. $\frac{32}{10}$ — 0 — 50 mf. (DBI)				

TABLE II (b)				
Type of Insulin	Onset	Peak	Duration of Action	Hyperglycemia
RAPID AND/OR SHORT ACTING:				
Crystalline				Late afternoon
Regular	1	2- 4	6- 8	Night
Semi lente	1	6-10	12-16	Evening-Night
INTERMEDIATE ACTING:				
Globin			18-24	
NPH	2-4	8-12	28-30	Before lunch
Lente			28-32	
LONG ACTING:				
Protamine Zinc	4-6	16-24	24-36	Before lunch
Ultra-lente	8	16-24	36-	Afternoon

ble in a few of these patients to give a mixture of a long acting insulin, Ultra-lente and semi-lente, a more rapidly acting insulin, before breakfast.

Adequacy of the insulin program employed may be evaluated by having the patient test his urine and keep a record of the tests taken before each meal and at bedtime, as well as noting any symptoms of hypoglycemia and the time of occurrence. In this way it is possible to raise the appropriate insulin to correct for glycosuria and in like manner lower the offending insulin causing any hypoglycemic symptoms. Smooth and adequate control of the diabetic state requires close cooperation between the diabetic patient and his physician.

Oral Hypoglycemic Agents

Ideally the hypoglycemic agents are reserved for the diabetic patient in whom normoglycemia cannot be maintained with diet alone, and in such cases diet should be maintained or continued after the addition of the oral compound in order not to encourage obesity in this group of patients. The patient most likely to respond to such agents has a maturity onset, past the age of 40, type of diabetes. If insulin therapy has been required, the dosage should be less than 40 units. The patient should not be underweight and the diabetes should not be prone to ketosis. A small percentage of obese diabetics, as mentioned earlier, may require a hypoglycemic agent in addition to diet to maintain normoglycemia.

Diabetic Acidosis

The occurrence of diabetic acidosis is a medical emergency and requires prompt diagnosis and institution of therapy. In the home or at the bedside it is possible to confirm the diagnosis in a matter of minutes and therapy need not be delayed while awaiting laboratory determinations. First, the urine contains four plus glycosuria. Second, a sample of blood is taken and placed in a test tube with sufficient potassium oxalate to prevent clotting. This is allowed to stand until a drop of clear plasma can be drawn

off the surface and placed on an Acetest tablet* or Acetone powder.† A deep purple color reaction indicates a four plus reaction for ketones, confirming the diagnosis of diabetic ketosis.³

The degree of ketosis and the initial insulin dosage may be determined by performing plasma acetone tests on serial dilutions of the plasma. The plasma is diluted with an equal quantity of saline or water and again tested. If a four plus reaction is obtained the serum is again diluted with equal quantities of saline or water and tested again. Four plus reaction in the undiluted plasma indicates only mild ketosis,

TABLE III
TREATMENT RECORD — DIABETIC ACIDOSIS

Date.....	Time.....	Name.....											
Hospital History Number.....													
Hours of Treatment:	0	1	2	3	4	5	6	7	8	9	10	11	12
Blood Sugar	*				*				*				*
Plasma Ketones	*		*		*		*		*		*		*
CO ₂	*				*				*				*
Blood Urea N.	*												*
Serum Potassium	*				*				*				*
Hematocrit	*		*		*		*		*		*		*
Urine Sugar	*		*		*		*		*		*		*
ketones	*				*				*				*
culture	*												*
analysis	*												*
EKG	*				*				*				*
Vital Signs	*	*	*	*	*	*	*	*	*	*	*	*	*
THERAPY: (Time, Dose, Route of Administration													
Insulin	‡	‡	‡	‡	‡	‡	‡		‡		‡		‡
Saline	‡	‡	‡	‡	‡	‡	‡						
Lactate					‡	‡	‡	‡	‡	‡	‡	‡	‡
Glucose								‡	‡	‡	‡	‡	‡
Potassium							‡		‡		‡		
Antibiotics	‡				‡				‡				‡

* Indicates intervals at which the respective studies are usually done.
‡‡ Indicates usual interval of therapy, see text for details.

in the 1:1 dilution moderate ketosis, in the 1:2 dilution marked ketosis, and 1:4 dilution and beyond would indicate profound ketosis. For each four plus reaction 100 units of regular or crystalline insulin is administered. Thus, if a four plus reaction were obtained in the 1:2 dilution 300 units, 40 per cent or 120 units intravenously and 60 per cent or 180 units subcutaneously. Additional insulin is given subcutaneously 50 units every hour until an appreciable decrease in ketosis is noted. As soon as the undiluted plasma gives less than a four plus reaction, the amounts of insulin administered are reduced sharply and the time interval between doses is prolonged to four to six hours.

A record of laboratory studies and therapy given during treatment of diabetic acidosis is essential. The record, kept at the patient's bedside, should contain information as to the values of the laboratory studies

obtained from hour to hour, amounts and route of insulin administered, blood pressure, pulse and respirations, amounts and types of fluids administered. Table III.

Fluids and Electrolytes

1. Initial replacement therapy is begun immediately. Depending on the degree of dehydration, 2000 to 3000 cc of physiologic saline solution is administered in the first four to six hours of therapy. Usually following the initial 2000 cc of saline within the first six hours, and with adequate insulin therapy, the ketonemia will show signs of clearing and one sixth Molar lactate in glucose is administered in order that an excess of chloride is not given. If the hematocrit values remain above 50 per cent and the systolic blood pressure remains below 90 mm. Hg., fluids may be given freely, 15 to 20 cc. per minute.

2. Potassium. Solutions containing potassium are rarely needed in the first four to six hours of therapy. If after four hours of therapy serum potassium levels are found to be low or an electrocardiogram indicates hypopotassemia, lowered T waves, depressed ST segments or lengthened QT interval or appearance of U waves, 40 mEq of potassium may be added to the infusion, not to exceed 25 mEq. per hour or 80 mEq. in twenty-four hours. As soon as the patient can retain oral fluids, one Gm. of potassium may be added to orange juice and given every hour for six doses.

Laboratory Studies

Secure immediately and at appropriate intervals as indicated on the treatment sheet: Blood sugar, plasma acetone, carbon dioxide combining power, blood urea nitrogen, serum potassium, urine for sugar, acetone, culture and urinalysis, electrocardiogram, and vital signs.

Subsequent Therapy During the Critical Phase

Severe or Profound Ketosis: Four plus reaction for plasma ketones in the first, second dilutions. Initial insulin dose 300 units. Subsequent insulin doses of 50 units are given subcutaneously at hourly intervals until an appreciable reduction of the plasma ketones, or an increase in the CO₂ combining power, is noted. Insulin dosage above these amounts will rarely be necessary, however, if after six hours of therapy there has been no decrease in plasma ketones or increase in the CO₂ combining power, each succeeding dose may be increased by 25 units until such changes are noted.

Mild or Moderate Ketosis: Four plus reaction for plasma ketones in the undiluted plasma only. Initial insulin dose 100 units. Subsequent insulin doses of 50 units given subcutaneously at three to four hour intervals until an appreciable reduction in ketonemia

* Acetest tablets manufactured by Ames Company, Elkhart, Ind.
† Acetone test powder manufactured by Denver Chemical Co.

occurs. In mild ketosis the danger of rapidly developing hypoglycemia may be avoided by giving 1000 cc. of five per cent glucose in water intravenously after six hours of therapy.

Indications for Reducing the Dose of Insulin

An appreciable reduction in the plasma ketones and an increase in the CO₂ combining power are indications of a lessening of the resistance to insulin. These findings should alert the physician to increasing insulin sensitivity and the possibility of a rapidly developing hypoglycemia. With the patient showing satisfactory progress, the insulin dosage schedule is prolonged to a four hour and then a six hour basis.

Administration of Carbohydrate

Glucose, a five per cent solution in water, 1000 cc. is given intravenously beginning six hours after the initiation of therapy. This may be repeated in six hours if oral fluids are not being retained.

Diet

After the ketosis has subsided and the administration of insulin has been spaced at six hour intervals the total daily calories are divided into four equal feedings, one-fourth given every six hours. The insulin dose is adjusted to the degree of glycosuria occurring prior to each feeding and is administered

prior to that nourishment. This regimen is then continued for 24 to 48 hours by which time suitable insulin adjustments have been made. At this time the patient's normal regimen and appropriate insulin may be instituted.

Note

At the time a diagnosis of diabetic acidosis is made, a thorough physical examination and search must be made to uncover any complication, such as an infection or myocardial infarction, which might account for the onset of the ketosis. Appropriate treatment of the complication is of extreme importance, for this will aid greatly in the therapeutic response of the diabetic acidosis. Repeated examinations are often necessary to uncover such a complication as pneumonia, for the classical signs are often absent in the presence of extreme dehydration and are only evident with hydration.

330 South 9th Street

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SURGEONS INDUCTED AS FELLOWS IN ATLANTIC CITY

Approximately 1,100 surgeons were inducted in Atlantic City, October 18, 1962, as new Fellows of the American College of Surgeons in cap-and-gown ceremonies during the annual five-day Clinical Congress of the world's largest organization of surgeons. The A.C.S., founded in 1913 to establish standards of competency and character for specialists in surgery, has grown in 49 years' time from a founding group of 450 to a total membership of approximately 25,000 in 79 nations.

Fellowship, entitling the recipient to the designation, "F.A.C.S.," following his name, is awarded to doctors who fulfill comprehensive requirements for acceptable medical education and advanced training as specialists in one or another of the branches of surgery, and who give evidence of good moral character and ethical practice.

Those receiving this distinction from the State of Georgia at the 1962 Convocation were as follows:

<i>Atlanta</i>	<i>LaGrange</i>
Ernest C. Atkins	Jennings M. Grisamore
Harrison L. Rogers, Jr.	
Luther C. Rollins, Jr.	<i>Macon</i>
William E. Schatten	Walter P. Barnes, Jr.
Robt. T. Willingham, Jr.	Lovick E. Dickey
	John I. Hall
<i>Augusta</i>	<i>Thomasville</i>
Daniel B. Sullivan	Alberto A. Zavaleta
<i>Dalton</i>	<i>Valdosta</i>
Murray B. Lumpkin	Joseph H. Brannen
<i>Decatur</i>	<i>Waycross</i>
James E. Anthony, Jr.	J. Duncan Farris

Biographical material regarding the above may be obtained from the physician's county medical society, his hospital, or his office.

FIRST LUMBAR ROOT SYNDROME

Lovick E. Dickey, M.D., *Macon*

■ *Vertebral nerve root blocks relieve the symptoms in many of these patients*

THE PURPOSE OF THIS PAPER is to call attention to a previously described neuralgic syndrome of pain occurring over part or all of the first lumbar segment, frequently associated with definite areas of localized tenderness. This disorder may be bilateral or unilateral and the symptoms are often confused with visceral pain patterns, particularly kidney and appendiceal ones. We feel that the origin of the pain is probably within the apophyseal joints and represents irritation of the nerve root secondary to arthritic changes, whether traumatic or degenerative and that the syndrome sometimes represents the residual of a back sprain.

Etiology

The dorsolumbar area of the spine has a greater mobility than any part of the vertebral column below the cervical region, and situated as it is, between two relatively immobile areas of the spine, is frequently subjected to injury. By far the great majority of vertebral fractures occur in this area and we feel that this syndrome may represent less serious degrees of injury. Postural defects no doubt are often involved in etiology and particularly have we noticed a large number of our patients with leg length inequality. The resulting scoliosis probably narrows the neural foramina sufficiently to result in symptoms on the concave side.

Symptoms

The distribution of pain in this syndrome may involve the entire segment of the nerve and frequently is associated with a twelfth dorsal neuritis also. Localization to a relatively small area is more

commonly seen, however. The posterior distribution of these two nerves covers the upper half of the buttock as far as the level of the greater trochanter of the femur. Medially, it is bounded by a line over and slightly medial to the margin of the sacro-iliac joint. Anteriorly, distribution covers an area of abdominal wall three fingers above and parallel to Poupart's Ligament, ending in the mid line. There is also a small area below and parallel to the ligament.¹ Almost always there is a site of maximal pain and tenderness at the edge of the erector spinae muscles opposite the center of the twelfth rib. Most of the people have not had significant injuries. A great majority of them are referred by urologists after negative pyelograms. Many have scars of appendectomies which fail to relieve their pain. Indeed Warren and Ballentine in a study of 138 cases of "chronic appendicitis" reported that 24.6 per cent of the patients were unimproved and .7 per cent were worse, and all were reported as having normal appendices.² The urologists tell us that the pain of acute renal colic can be relieved by blocking these two nerve roots, and commonly the patients have a history of previous renal colic or proven attacks of stones. We believe that the location of the problem in these cases is close to the nerve trunks as they emerge or else is intraforaminal. Muscle spasm is generally not present and sensory changes are unreliable, although we have noted that many patients have decreased sensation over the dermatome area. Motions of the spine are usually not uncomfortable. Cough and sneeze aggravation of pain is commonly absent and reflex changes, as might be expected, are not present. Neither are there leg signs of nerve

Presented at the 108th Annual Session of the Medical Association of Georgia, May 6, 1962, Savannah, Georgia.

root pressure. X-rays of the lumbar spine are generally negative.

Treatment

It has been our experience that vertebral nerve root blocks relieve many of these patients. In a few instances we have used epidural blocks. Heel lifts are routinely prescribed in all cases of inequality and may be quite helpful. Descriptions are given in the literature of complex methods of treatment of this syndrome, including bracing and even spinal fusion,³ but it has been our frequent experience that blocks, often times a single block, will relieve patients who have had the disorder for many years.

Technique of the Block

The patient lies in a prone position with a pillow under the lower abdomen. The spinous processes of the first and second lumbar vertebrae are located by palpation with particular orientation to be gained from the twelfth rib. A line is projected at right angles to the long axis of the spine at a point overlying and tangential to the upper edge of each spinous process. Three centimeters from the spinous process of the first lumbar vertebra laterally along this line, a wheal is raised with the local anesthetic and the same method is repeated opposite the second lumbar spinous process, laterally an additional one half centimeter. A three inch needle is passed directly

down to the transverse process which lies generally 2.5 to five centimeters deep. The needle is then withdrawn slightly and directed in the cephalad direction approximately one centimeter beyond the transverse process. The needle is kept parallel with the sagittal plane of the body. The pain pattern is often reproduced during the needling or the injection. Care is made to be certain the needle is not in a blood vessel or intrathecally. Five ccs. of the solution is then injected at each trunk. Following reports of others of relief of peripheral nerve pain with hydrocortisone injections, we have often added one cc. of this solution to our injection.

Summary

Attention is drawn to a previously described cause of back pain, with the hope that this pain pattern may be recognized more often in the maze of causes of backache. A method of treatment is presented which generally has been satisfactory in our hands.

671 Hemlock Street

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MEDICAL SEMINAR A FIRST FOR THOMASVILLE

More than 100 physicians and leading medical authorities from the Southeast and other parts of the country assembled September 20, at Archbold Memorial Hospital for the first two-day medical seminar ever held in the Thomasville area.

The visitors joined Thomasville's 35 practicing physicians to hear distinguished medical authorities discuss new trends and concepts in many fields of medical science.

Discussions Thursday, September 20, featured Dr. Gilbert D. Barkin, pediatrician and allergist with the Pavlovian Laboratory, VA Hospital, Perry Point, Maryland, in a discussion of "Current Concepts on the Management of the Asthmatic Child."

Dr. Frank Spencer, professor and chairman of the Department of Surgery at the University of Kentucky, spoke on, "Treatment of Peripheral Vascular Disease," while Dr. William Hollander, of Massachusetts Memorial Hospital discussed, "Hypertensions."

Of special interest were the many displays set up in the hospital conference room lobby by manufacturers of medicines, drugs and hospital equipment.

The new Pake X-ray film processing machine held considerable attention. The device completely processes X-ray film in about seven minutes, as opposed to

about two hours required by manual methods.

With this device, it is conceivable that an accident or emergency patient could be thoroughly examined, X-rayed and prepared for surgery [with authenticated diagnosis complete] in about 20 minutes.

Another new device viewed by local physicians was the Cambridge Trans-scribe electrocardiograph, transistorized portable device weighing less than 18 pounds.

Visiting physicians, their wives and guests were entertained Thursday, September 20, at a skeet shoot at Greenwood Plantation; a golf tournament at Glen Arven; bowling at Rose Lanes; and a fishing expedition at Myrtlewood Plantation.

A barbecue supper was served at 6 p.m. at Coats & Clark Recreation Center.

The seminar continued Friday at 9 a.m. Dr. Robert W. Talley, senior staff physician, Oncology Division, Henry Ford Hospital, Detroit, Michigan, discussed, "Chemotherapy of Malignant Disease;" Dr. Dwight Harken, associate clinical professor, Harvard Medical School, talked of, "The Changing Responsibility of the Physician in Relation to Heart Surgery;" and Dr. William ReMine, Department of Surgery, Mayo Clinic, presented a paper on, "Surgery of the Thyroid Gland."

SEVERE DEAFNESS IN AN INFANT FOLLOWING ORAL ADMINISTRATION OF NEOMYCIN

James T. King, M.D., *Atlanta*

■ *The hearing loss developed one week after the ingestion of less than two grams of this agent.*

THE PURPOSE OF THIS REPORT is to warn of potential hearing loss after ingestion of relatively small doses of neomycin in certain hypersensitive individuals who seem more prone to develop drug induced deafness, acoustic trauma (noise induced deafness), early presbycusis, and nerve deafness.

Injected neomycin is notoriously audiotoxic, causing severe degeneration of the hair cells in the Organ of Corti,¹ but it has been thought there was so little gastrointestinal absorption that this effect could be disregarded when the drug was given by mouth. However Last and Sherlock² warn this assumption is unwarranted since they found significant blood levels of neomycin in several such instances which were not related to the dosage or duration of therapy. Furthermore, Short et al³ have shown that peritoneal absorption of neomycin is sharply increased when this membrane is irritated. The possibility of sufficient assimilation through an inflamed gastrointestinal tract to cause severe, lasting deafness is shown by the following case.

Case Report

A baby girl, 18 months of age, who had hearing loss in addition to repeated attacks of throat and ear infection was seen by me on June 3, 1960. The referring pediatrician said she was normal except for this affliction. The father disclosed he developed

moderate hearing loss after brief exposure to gunfire during the Korean War.

On January 15, 1960, while living in another city during an outbreak of viral gastroenteritis, the child had been taken with diarrhea, fever, and then vomiting. Two days later there was no improvement, and she was admitted to a hospital. Except for moderate dehydration, an increase in tissue turgor, slight leucocytosis and albuminuria, the usual studies and examinations were reported normal. No further kidney function studies were made. Kaopectate with Neomycin® (contains 300 mg. neomycin sulfate per fluid ounce—PDR) was given orally, one teaspoonful every four hours. Two intramuscular injections of aqueous procaine penicillin—400,000 u—were given also. By January 20, her condition had improved enough for her to be sent home where the oral medication was continued for four more days by which time she had recovered. The total amount of neomycin taken was computed to be less than two gms.

Shortly thereafter, the mother began to notice a diminution in hearing which became steadily worse and by mid-February there was a question whether the child could hear at all. Infantile articulate sounds were no longer attempted. At the time I saw the patient, some four months later, bilateral serous otitis media and low grade adenotonsillitis were present. She was obviously deafened, showing little

Presented at the Henrietta Eggleston Memorial Hospital Staff Conference September 21, 1960.

or no response to loud auditory stimuli, but vestibular function seemed normal. Arrangements were made for the hearing to be tested at the Atlanta Junior League School for Speech Correction. Meanwhile, although the severity of the hearing loss was not commensurate with the middle ear findings, an adenotonsillectomy and bilateral myringotomy with tympanotubal lavage was performed at Henrietta Egleston Hospital without difficulty on June 16. Two weeks later the middle ears and throat had returned to normal and remained so.

The audiologists' report on June 28, said in part, "We obtained no responses below a very high level of intensity, but when the stimulus was extremely loud, we observed a number of very consistent responses. At an 80 decibel level she responded over and over to the tester's voice. At the same level she pointed to the loud speaker when a drum was beaten . . . she gave us enough responses for us to feel that very probably an extremely strong hearing aid will be of help when she is in a training situation."

As of the present, the mother says that while the child seems normal otherwise, the hearing is still quite defective.

Comment

Neomycin, given orally, is valuable in the production of intestinal antisepsis, finding its greatest worth in the treatment of hepatic failure and preparing certain patients for bowel surgery.⁴ However, it is not enough to caution that these cases should have careful observations of hearing acuity and any impairment should call for withdrawal of the drug. In

the case at hand, this would have helped not at all since hearing loss did not become apparent until at least a week after treatment had ended, this coinciding with the observations of Waisbren and Spink.⁵ It would seem that the presence of detectable quantities of circulating neomycin would be a more reliable index of imminent audiototoxicity.

Summary

An infant, whose father had acoustic trauma, became severely deafened following ingestion of a compound (Kaopectate with Neomycin®)* commonly used in the treatment of enteritis. The presence of serous otitis media in association with adenotonsillar infection was a coincidence.

The presence of a family history of deafness and/or susceptible acoustic nerves warrants extraordinary caution in administering neomycin orally.

340 Boulevard, N.E.

* Recently withdrawn from "over the counter" purchase.

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TEENAGERS PROVE SUCCESS AS SUMMER VOLUNTEERS IN NATION'S VA HOSPITALS

Thousands of teenagers did a grown-up job this summer as volunteers at the Veterans Administration's 169 hospitals across the nation.

In addition, VA officials said, the teenagers often developed interest in careers in medicine, nursing, and related fields. For many, the VA service provided valuable experience toward their life work goals.

Serving as junior volunteers, they were engaged in "Operation Summer Replacement," to fill the gaps left at the VA hospitals by absence of older volunteers on vacation.

With both patients and VA staff members, the juniors are an unqualified success.

The minimum age for volunteers at most of the hos-

pitals is 15. Those 16 and older do most of the tasks their adult counterparts do to help veteran-patients. The younger "juniors" are limited to tasks not involving contact with patients.

Junior volunteers usually spend one day a week at the VA hospitals, and many of them turn up for additional duty.

Both boys and girls work in pharmacy, dietetics, dental service, hospital libraries, educational therapy activities, hospital recreation and radio programs, and in escort service taking disabled veterans to and from clinics and therapy rooms.

They also shop and write letters for patients and do errands such as delivering books and flowers to wards.

THE LOCHIA HAS CHANGED

Arthur A. Smith, M.D., *Atlanta*

■ *Normal contemporary women have a different postpartum bleeding pattern than is described in most textbooks of Obstetrics*

TIMES CHANGE. And so has the lochia. The thing that has not changed is the antiquated classification of the lochia found in even the most recent Obstetrical textbooks.

Eastman and Hellman¹ state in their textbook published in 1961 that the lochia rubra is a blood stained fluid which occurs for the first few days after delivery. They say that this is followed by the lochia serosa which lasts from the fourth to the tenth day. Then, after this, comes the lochia alba which is a whitish or yellowish discharge.

Fifty years ago in 1911, J. Whitridge Williams² said in his textbook of Obstetrics that the lochia rubra was a bloody discharge that lasted three to four days. This was followed by the lochia serosa which was a pale red and brownish discharge which lasted until the tenth day. After the tenth day the lochia alba which is a whitish or yellowish discharge appears.

Other textbooks spout the same line, i.e., lochia rubra—four days, lochia serosa—four to ten days and lochia alba from then on.

This is not true today. It is about time that nurses, medical students and young doctors starting in practice be made cognizant of this fact.

Since it has been this investigator's impression for many years that normal contemporary women have a different postpartum bleeding pattern than stated in the textbooks of Obstetrics, he has undertaken

this present study to determine just what type and how much postpartum bleeding should be considered normal.

Material and Methods

One thousand women were queried about their various types of lochial discharges and the approximate duration of each type. These questions were asked at the time of the six week postpartum check-up so that their answers would be fairly accurate. These questions were asked actually of over one thousand consecutive patients, because only women who had normal spontaneous vertex deliveries are included in this report. Excluded from this report are all others including women who had caesarean sections, postpartum hemorrhage from any cause, tubal ligations, women who required dilatation and curettage in the postpartum period, forceps deliveries, breech deliveries, and women who nursed for awhile and then switched to the bottle before the six week check-up.

Results

It was found that the lochia rubra lasted two and one half weeks (2.44 weeks) in non-nursing mothers and less than two weeks (1.81 weeks) in nursing mothers. The lochia serosa lasted about two weeks (2.06 weeks) in non-nursing mothers and a little over two and one half weeks (2.64 weeks) in nursing mothers.

These statistics show also that postpartum bleeding lasts normally about four and one half weeks

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whether a woman is nursing (4.45 weeks) or not nursing (4.50 weeks).

It is interesting to note that only 19.5 per cent of the one thousand women nursed their babies, while 80.5 per cent bottle fed their babies. This is in keeping with infant feeding attitudes and customs which have evolved in the past two decades.

Activity Determines Variation

The lochia of a small percentage of women will alternate from red to brown and vice versa. This, of course, is due to the amount of activity that these women undertake. If they obtain more rest the red lochia will again turn brown and subsequently become clear. A return to more profuse red lochia occurs frequently when the postpartum exercises are commenced. This is consistent with the fact that the more the activity, the heavier the bleeding.

Incidentally, it was found also in this study that bleeding lasted longer than the average length of time in women who have a retrodisplaced uterus. Indeed, many conscientious patients cancelled their six weeks examination appointments because they were still bleeding. When they did come in after two months or so, invariably it was found that the uterus was retrodisplaced.

There were a number of women in this series who had had two babies while this study was in progress. Consistent with the aforementioned findings, is the fact that of those who nursed one time and bottle fed the next, that the lochia rubra did not last as long when they nursed.

Discussion

At the beginning of this study an oral estrogen was being used for the suppression of lactation. However, the majority of non-nursing mothers were given an estrogen-testosterone preparation intramuscularly in the recovery room as soon as they were awake enough to make their wishes concerning nursing known. It might be stated here that as far as the amount and duration of postpartum bleeding was concerned that there was little difference from oral or intramuscular therapy. The intramuscular therapy did have other advantages, however.

The author agrees with Eastman³ that the advantages of early ambulation are numerous. The patients get their strength back sooner. There are less cases of retention of urine after delivery. The frequency of catheterization is greatly reduced. Constipation is less of a problem. Distention is less of a problem. The incidence of thrombophlebitis is reduced. And a shorter hospital stay is easier on the pocketbook.

Eastman goes on to state that it is now the general

custom to allow patients out of bed 24 to 72 hours postpartum. What is not said is that for a patient to have a typical Obstetrical textbook picture lochia, she must stay in bed for ten days to two weeks, since with early ambulation and increased activity has also come increased and prolonged uterine bleeding. This increased and prolonged bleeding is normal if we are going to continue early ambulation as it seems we are. Thus, the title of this paper evolves, "The Lochia Has Changed." It has changed because of early ambulation. What was once considered abnormal bleeding fifty years ago, yes, even twenty years ago, must now be considered normal.

Barcom⁴ states in her book on Obstetrical Nursing published in 1933 that the patient is allowed to sit up out of bed in a chair for a little while about the ninth or tenth day.

Instructions Have Changed

Williams states in the same book in which he categorizes the lochia, that the patient is kept flat in bed and not allowed to sit up in bed until the tenth day. He states that, generally speaking, two weeks in bed is not excessive. He goes on to say that the patient should be confined to her room for the first three weeks and not allowed to go up and down stairs until four weeks have elapsed. How changed these instructions are nowadays! The lochia has changed, also.

This author has no quarrel with early ambulation. He just wants students taught what is occurring nowadays, not fifty years ago. He wants the discussion of the lochia in the textbooks brought up to date.

From the results of this study it can be seen that many non-nursing women go right from their four and one half week bloody lochia into a menstrual period. If one does not realize this, he may believe that she has a case of delayed postpartum bleeding since the first period after delivery is heavier than usual in most cases. If all of these facts are not realized and the young doctor is following what he was taught in medical school, he will perform many unnecessary D and C's, prescribe much unnecessary ergot preparations, give many unnecessary injections of his favorite hormone combination to decrease bleeding, and cause the patient and her family much unnecessary anxiety, not to mention the added expense.

Inadequate Textbook

When a patient calls her young doctor and tells him that the baby is three and a half weeks old and she is still bleeding, he looks in his favorite Obstetrical textbook. It tells him that this indicates the retention

of a small portion of the afterbirth or imperfect involution of the uterus. He tries to think back to remember if he could have possibly forgotten to inspect the placenta. On the other hand the patient is thinking, but not saying, that he did a poor job and left afterbirth in her. Thus, for all these reasons, including medico-legal, it is important for the textbooks to contain and the public to know, what actually is normal postpartum bleeding nowadays.

In most cases, when the postpartum patient complains on the telephone that she is bleeding too much, if she is instructed to get help and stay in bed for a few days, the bleeding will decrease or cease, exactly as it did in her grandmother's time.

Summary and Conclusions

1. In this author's private practice approximately twenty per cent of the women nurse their babies.

CASH AWARDS OFFERED IN CONTEST

The Council on Undergraduate Medical Education of the American College of Chest Physicians offers three cash awards to be given annually for the best contribution prepared by undergraduate medical students on any phase of the diagnosis and/or treatment of chest diseases (heart or lungs).

The first prize will be \$500; second prize will be \$300; and third prize, \$200. Each winner will also receive a certificate of merit.

The winning contributions will be selected by a committee of chest specialists and will be announced at the 29th Annual Meeting of the American College of Chest Physicians to be held in Atlantic City, June 13-17, 1963. All manuscripts become the property of the American College of Chest Physicians.

Those wishing to enter the contest must observe the following conditions:

- (1) Complete the official application form in duplicate, have original copy signed by the dean of the medical school, and return original copy at once to College offices.
- (2) Five copies of the manuscript, typewritten in English (double spaced) should be submitted to the College offices in Chicago not later than April 1, 1963.
- (3) The only means of identification of the author shall be a motto or other device on the title page. A sealed envelope bearing the same motto on the outside and enclosing the name and address of the author must accompany the essay.

It is suggested that applicants study the format of the College journal, *Diseases of the Chest*, to guide them in the preparation of the essay.

The official application form, sample copies of the journal, and additional information may be secured by writing Mr. Murray Kornfeld, Executive Director, American College of Chest Physicians, 112 E. Chestnut St., Chicago 11, Illinois.

2. The lochia rubra will not last as long in nursing mothers as in non-nursing mothers.

3. If a woman will stay in bed for ten-fourteen days after delivery, she will have little or no bleeding upon arising until the onset of her first menstrual period.

4. The woman of today with early ambulation, early activity, early assuming of the household chores, etc., should expect to have some bleeding for an average of four and one half weeks, not ten days.

1102 West Peachtree, N.W.

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INSTITUTE REPORTS RECEIPTS

The American public received more than \$600,000,000 in benefits from insurance companies during 1961 to help pay for the cost of surgery, the Health Insurance Institute reported recently.

The \$623,000,000 in surgical benefits was an increase of 13 per cent over the \$552,000,000 paid out by insurance companies in 1960 to persons covered by surgical expense insurance, or by major medical expense insurance that provides benefits for operative procedures, said the Institute.

At the end of 1961, nearly 79 million persons had surgical expense insurance through insurance companies. Blue Cross-Blue Shield and similar groups covered more than 50 million persons for surgery, and other health care groups protected 6.8 million. After deducting persons protected by more than one type of insuring organization, there was a net total of 125.3 million persons with surgical insurance, compared to 121.0 million persons a year earlier, the Institute said.

Over 135 million persons had hospital insurance at the end of 1961 which means, said the Institute, that 93 per cent of persons with health insurance have both hospital and surgical insurance.

Both the number of persons covered by insurance company surgical policies and the amount of surgical benefits paid by insurance companies are increasing steadily, with the growth in benefits outpacing the climb in coverage, the Institute said.

Coverage increased from 75.3 million in 1960 to 78.9 million in 1961, a boost of 4.8 per cent, while benefits increased 13 per cent in the same period.

A comparison of a longer period, from 1956 to 1961, shows that surgical benefits increased more than two-and-a-half times as fast as the number of persons covered by surgical insurance, said the Institute.

In the five years, the coverage went from 63.0 million to 78.9 million, an increase of 25 per cent, while benefits climbed from \$369 million to \$623 million for an increase of 69 per cent.

EARLY RADIOLOGY IN SAVANNAH, GEORGIA

David Robinson, M.D., *Savannah*

■ Considerable pioneering work in this specialty was carried out by Georgia doctors

RADIOLOGY IS ONE OF THE MOST RECENT specialties in the field of Medicine. It had its origin with the discovery of X-ray by Dr. William Conrad Roentgen in 1895. Although the age of this specialty is relatively young as compared with the over-all age of Medicine, the rapid strides that have been made in the field of Radiology during the past few decades make each passing day another milestone in its history.

In my research into the past history of early Radiology in Savannah, Georgia, I was surprised to find the name of Dr. John Wesley. John Wesley, the Father of Methodism, was also a lay physician. In 1755 he published a unique collection of 829 receipts for 288 conditions utilizing the Electro-Static Machine. This machine, as described in Monell's *Manuel of Static Electricity in X-ray and Therapeutic Uses*⁴ was used in the latter part of the 19th century to supply the source of electricity to the X-ray tube.

Variety of Conditions

Briefly, some of the conditions treated by Dr. Wesley according to his volume entitled *Primitive Physic* were baldness, bruise, burn, dropsy and lunacy. His use of this apparatus in treating mentally ill patients would perhaps label him as one of the first Psychiatrists using electro-shock therapy.

During its infancy and for the first decade of the 20th century, from 1896 to 1913, the development of the field of Radiology in Savannah was due to the ingenuity, labor, and research of one individual—Dr. Eugene R. Corson. I have freely drawn my material from the excellent biography on Dr. Corson which was written by Dr. E. H. Skinner⁶ in 1931. I have also had the pleasure of conferring with Mrs. Pauline C. Coad,¹ one of Dr. Corson's daughters who still resides in Savannah at 11 West Jones

Street, across the street from her father's old office and home. Additional information on Dr. Corson was obtained by delving into the files of the Savannah newspapers.⁵

History

Dr. Corson was born in Washington, D.C., on July 20, 1856. He was educated in private schools and at St. John's College at Annapolis, Maryland. He entered Cornell University in 1871 and received his B.S. degree in 1875. He received his first degree in Medicine in 1877 from Hahnemann Medical College in Philadelphia. As Hahnemann was a school of the Homeopathic doctrine, he studied and received a second degree in Medicine from the Southern Medical College in Atlanta, Georgia, in 1894.

Dr. Corson did postgraduate work in Vienna, Austria. Searching for a warm climate because of his health, he settled in Savannah in 1879. He became actively engaged in the practice of Medicine and Surgery in Savannah, at the same time pursuing many cultural interests. In November 1895, while reading a copy of the New York Staat-Zeitung, a German newspaper, he was fascinated by the description of the X-ray by Dr. Roentgen. Dr. Corson stated, "I had long been familiar with Dr. Crookes' experiments with electrical discharges through a more or less high vacuum and his theory of radiant matter." Dr. Corson procured a Crookes tube and utilizing a small coil, produced the first radiograph in Georgia—a plain key. It took about 30 minutes exposure for this X-ray to be made.

Dr. Corson continued to improve the coils for his generators and in 1902 refused to accept Dr. Roentgen's opinion that the Holtz (electro-static) machine was equal to the induction coil. His arguments were proven valid, as we know that the production of X-ray for diagnosis and therapy depends on the greater voltages that only the modern transformer can provide. When Snook perfected his mechanically

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rectified unit in 1910, Dr. Corson was elated. He knew the importance of speed and intensity in effecting a satisfactory radiograph.

First Paper Appeared in 1897

I was very fortunate in obtaining the original copies of Dr. Corson's earlier works. These were loaned to me by his daughter, Mrs. Coad. His first paper dealing with the roentgen ray appeared in the New York Medical Record on May 8, 1897. This was on Colles' fracture. Later in the same year, another paper was published on X-ray technique.

In 1898, Dr. Corson published an "X-ray Study of the Normal Movements of Carpal Bones and Wrists." During the investigative study of this work on the carpal bones, Dr. Corson was both the subject and investigator. As a result, radiation effects showed up ten years later in the form of epitheliomata on four fingers of the left hand, three of which were subsequently amputated.

Surgery Curtailed

Being primarily a Surgeon, Dr. Corson continued to operate after the first digit was removed by tying back the empty glove finger so that it would not impair his movements. However, as the other fingers were subsequently removed, he discontinued his surgical work.

Dr. Corson published a number of other medical articles through the early years of the present century. In April 1905, he published a paper on ureteral stone, diagnosed by X-ray. This was operated upon and proven. This is the first such case reported in Savannah and is perhaps one of the earliest cases in world literature.

In addition to his medical interests, Dr. Corson enjoyed many attainments in other fields. He was the author of the monograph entitled, "The Future of the Colored Race in the U. S. from an Ethnic and Medical Standpoint." This became required reading in many universities during the earlier years of this century. Among his cherished possessions was a fine collection of the works of Sir Charles and John Bell.

Opinions and Activities

Dr. Corson stated, "It warmed the cockles of my heart to meet men who were interested in the Science of Medicine and not in its mere every-day practice." By checking through the local newspaper files, I was able to review the plentiful opinions and activities of Dr. Corson. In 1937, he was honored by the Georgia Medical Society at a large banquet. He con-

tinued to practice in a limited way during the later years of his life, although he was somewhat handicapped by his amputated fingers. He was active and alert and continued to keep abreast with modern medical developments to the time of his death at the age of 91 in 1946.

In addition to his office at 10 West Jones Street, Dr. Corson was the Roentgenologist at the old Savannah Hospital (now Warren A. Candler Hospital) as well as the St. Joseph's Hospital and Central of Georgia Hospital.

Ideas From History of Medicine

Dr. Corson fulfilled the ideals of the well-rounded practitioner of Medicine as described in Dr. F. H. Garrison's *History of Medicine*³—"For the medical student and practitioner, the study of the history of his profession, dealing as it does with all aspects of human culture, affords one of the best outlets for ideation, and is also one of the best offsets to the mental staleness and ennui which result from narrow specialism and infatuation with a single idea."

The second radiologist in the early days of this specialty in Savannah was Dr. W. A. Cole (1884-1958). Dr. Cole graduated from the Georgia Medical School in 1913. He interned at the old Park View Sanatorium from 1913 to 1916 at which time he became Vice President and Chief of Staff. He was in charge of the X-ray Department at the Telfair Hospital until he was relieved by Dr. Robert Drane in 1919. He also operated the X-ray Department at the Warren A. Candler Hospital and St. Joseph's Hospital. He served as Chief of Staff of the Warren A. Candler Hospital from 1933 to 1946 and was its Radiologist until his death in 1958.

1919 to 1962

Dr. Robert Drane arrived in Savannah in 1919 and relieved Dr. Cole at the Telfair Hospital. He did relief work for Dr. Corson as well. Just before World War I, a crude X-ray machine was installed in the Oglethorpe Sanatorium. Dr. Drane has been in charge of the X-ray Department at the Oglethorpe Sanatorium from 1919 to this date. He established his office in the Derenne Apartments where he is still located.

This paper has covered the first quarter century of Radiology in Savannah, from 1896 to 1922. We have gone from the Crookes' tube and induction coil to the power transformer and Coolidge tube. We have made many strides during the subsequent years, but most are refinements of the experiments and inventions of those who have preceded us. It would do us well to remember one of the last quotations from Dr. Corson who said, "There is

not one of the sciences which has made the strides which have taken place in molecular and X-ray physics, the real fairy tale of the sciences; and think of the next 100 years when even more willing ears will listen to the great fairy tales of science, when you and I, like streaks of morning clouds, shall have faded away into the infinite azure of the past."

9 Medical Arts Center

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JMAG STAFF MEMBERS ATTEND WESTERN MEDICAL JOURNAL CONFERENCE

Denver, Colorado, was the setting for the Fourth Biennial State Medical Journal Editor's Conference held November 3 and 4, 1962, at the Denver Hilton Hotel. The Program was under the auspices of the *Rocky Mountain Medical Journal*, which serves six Western states—Colorado, Montana, New Mexico, Utah, and Wyoming.

The Biennial State Medical Journal meetings originated under the direction of the staff of the *Journal of the Medical Association of Georgia*. The first meeting of its kind was held in Atlanta in 1956.

Experts Speak

The program encompassed all phases of medical journal production and each point was emphasized by a speaker, expert in his particular field. Speaking on medical journal production in 1963 was Mr. John C. Foster, Business Manager of the *South Dakota Journal of Medicine and Pharmacy*. Following up Mr. Foster's introductory speech was Mr. Alfred Hoflund of Denver, who spoke on the typography and design of the modern medical journal. Mr. Hoflund pointed out the obvious errors of various state journals and advised that comprehension and readability were of utmost importance in a journal. The best features of several journals were emphasized and Mr. Hoflund stressed the lure of color, form, and texture as three of the most desirable points to incorporate in a journal. Contrast of headlines and sub-heads for the greatest optical effect, and color within the editorial material was recommended by the speaker, who is a member of the Hoflund-Schmidt Typographic Service of Denver.

Color Again Emphasized

Color was again a main point of emphasis in the talk given by Mr. Gilbert Cooper, Managing Editor of the AMA specialty journals, Chicago. Although he feels color is important in illustrations, Mr. Cooper pointed out that it is more widely used in specialty journals and should it be used in a state medical journal, there should be specific reasons. He also advised about the manner in which one may obtain the best results from the engraver, which in turn will please the advertiser.

Mr. Ralph Rauscher, President of the Publisher's Press, Inc., of Denver, spoke on how to achieve the best results with your printer, and to further his point, in-

troduced his chief printer who brought out the detailed job of the printer in working with the production manager of any medical journal. Closer liaison between these two important journal personalities was stressed to maintain the best possible standards for each medical journal.

Dr. Douglas Macomber, Chairman of the Editorial Board of the *Rocky Mountain Medical Journal*, and Dr. Edgar Woody, Atlanta, Editor of the *Journal of the Medical Association of Georgia*, reported on the problems, old and new, of the medical editor. Specific points were placed on the function of assistant editors, modern medical writing styles, the author and problems concerning him, and the observance of publication rules.

Advertising, the Mainstay

Advertising, the mainstay of publications, was highlighted by Dr. Theodore Klumpp, New York City, President of Winthrop Laboratories. Dr. Klumpp, who has figured largely in trying to combat stringent federal action taking place against advertising drug laws, explained what the newest federal drug advertising laws and FDA regulations will mean to the pharmaceutical manufacturers and the medical journals.

Local Advertising Overlooked

Reemphasizing the points which Dr. Klumpp had brought to the forefront and giving a short resume on the past and future of the State Medical Journal Advertising Bureau, was Mr. Alfred J. Jackson, Chicago, President of the advertising organization. Closing the session was Mr. Billy Prescott, President of Prescott-Hull, Inc., advertising firm of Denver. Mr. Prescott aimed at the importance of local advertising in medical journals. Products that are being overlooked because they do not appear to relate to the medical field offer a wealth of revenue to the medical journal which has not already tapped its resources, he pointed out.

Idea exchange sessions between members of medical journal staff members followed the lectures. Sharing one another's problems and high spots made for a most interesting meeting and gave each member of the group a sense of enthusiasm, understanding, and encouragement. But most important, the courage to return to his state's medical journal with renewed aims and ideas.

CLINICAL EVALUATION OF POLYTHIAZIDE IN EDEMA OF OBSTETRICAL, GYNECOLOGICAL, AND MISCELLANEOUS DISORDERS

William E. Barfield M.D., and Edwin C. Jungck, M.D., *Augusta*

■ *This agent administered once daily was found to be an effective and relatively safe oral diuretic in one hundred twenty-five patients*

THE CLINICAL USEFULNESS of the thiazide compounds as oral diuretic agents has been established. The purpose of this clinical study was to determine the diuretic effectiveness and the minimal effective dose of a new thiazide derivative, polythiazide,* in the management of edema in pregnancy, the premenstruum, and other selected disorders.

The chemical structure of polythiazide differs from that of chlorothiazide by the addition of a methyl group in the 2-position. On the basis of increased sodium excretion in laboratory animals,¹ the relative potency of polythiazide was shown to be 1.9 if 1.0 is assigned to the potency of trichlormethiazide. Polythiazide was found to be a less potent carbonic anhydrase inhibitor than acetazolamide, but more potent than chlorothiazide or hydrochlorothiazide.¹ Polythiazide has been shown to be a potent oral diuretic with prolonged action,² with a milligram for milligram effectiveness considerably greater than that of chlorothiazide.^{3,4}

Methods and Materials

Polythiazide was administered orally in a single daily dose each morning to 125 patients with edema. The dose was varied from 0.5 to 8.0 mg. in all patients except one who received 16.0 mg. There were 51 patients with edema of the third trimester of pregnancy, 12 patients with premenstrual edema, and 62 patients with edema of varied etiology. These

consisted of 17 menopausal patients, 21 patients on low calorie diets for management of obesity, 14 patients with hypothyroidism, four patients receiving corticosteroid therapy for rheumatoid or osteoarthritis, one patient with severe diurnal edema and functional hypoglycemia, and five patients with edema of undetermined etiology.

Twenty-five patients were available for this study from the University Hospital outpatient clinic of the Department of Endocrinology of the Medical College of Georgia, and the remainder were private patients. No dietary restrictions were advised and, except when specifically indicated, no adjunctive therapy was prescribed.

Serum and urinary electrolyte determinations were obtained on 25 selected patients, and daily weight records were requested of all patients. In most instances, weekly observations of weight changes and clinical evaluation of edema were possible.

Observations and Results

A prompt and adequate diuretic response with demonstrable reduction of edema was observed in all but one of the 125 patients treated (Table I).

TABLE I
POLYTHIAZIDE
0.5 mg. to 16 mg. daily

Number of Patients	Diuretic Response	
	Adequate	Inadequate
125	124	1

From the Department of Endocrinology, Medical College of Georgia, Augusta, Georgia.

*Polythiazide (Renese) was supplied by Dr. Albert E. Woeltjen, Associate Medical Director, Pfizer Laboratories.

TABLE II
DETERMINATION OF MINIMAL EFFECTIVE DOSE OF POLYTHIAZIDE
FOR CONTROL OF EDEMA IN PREGNANCY
51 Patients

Polythiazide— Single Daily Dose	Number Patients	Diuresis and Control of Edema	
		Adequate	Inadequate
0.5 mg.	18	10 (55.5%)	8
1.0 mg.	18	12 (66.6%)	6
2.0 mg.	40	37* (92.5%)	3
4.0 mg.	7	7	0
6.0 mg.	1	1	0

*2 mg. every other day proved adequate in 6 patients

Diuresis was observed in most instances within two to three hours after ingestion of the medication. A single daily dose of 2.0 mg. to 4.0 mg. during the mid-morning was adequate to control edema for at least twenty-four hours. Eight patients reported that a 2.0 mg. dose every other day was adequate to prevent recurrence of the edema.

Edema of Pregnancy

Polythiazide was administered to 51 patients with demonstrable pretibial and pedal edema of the third trimester of pregnancy. No dietary restrictions were suggested. The initial dose of 0.5 mg. polythiazide daily to 18 patients proved inadequate to control the edema in eight patients (Table II). When the dose was increased to 1.0 mg. daily, 12 (66.6%) of the 18 patients responded satisfactorily, and in only six was the response considered inadequate.

Adequate diuresis and control of edema was observed in 37 of 40 patients (92.5%) who received 2.0 mg. polythiazide daily. The six patients with inadequate response to 1.0 mg. responded well to 2.0 mg. daily. All three patients who failed to respond to the 2.0 mg. dose responded satisfactorily to 4.0 mg. daily.

In this series of patients a single daily dose of 2.0 mg. polythiazide produced adequate diuresis and control of edema in 92.5 per cent of the patients treated for edema in the third trimester of pregnancy. Although 1.0 mg. polythiazide proved adequate for 12 of 18 patients (66.6%), eight of the 51 patients (15.7%) obtained more complete control of edema when the dose was increased to 2.0 to 4.0 mg. daily. Six patients in this series reported that a single dose of 2.0 mg. every other morning proved adequate to control edema. From these observations, therefore, the optimal initial dose appeared to be 2.0 mg. polythiazide daily.

The duration of treatment was from two to 12 weeks in this group of patients and development of drug resistance was not observed. Onset of diuresis within 45 minutes was reported by one patient, and obvious loss of edema within 24 hours after beginning treatment was usual. Weight loss of four to eight

pounds was observed frequently during the first week of treatment, and adequate control of edema with normal expected weight gain of pregnancy followed with continued therapy. Undesirable symptoms associated with rapid diuresis occurred in 12 of the 51 patients treated. These symptoms, including muscular weakness, leg cramps, constipation, excessive thirst, and salt-craving were the same as those observed in the non-pregnant patients in this study. In all except five of the 12 patients with such symptoms, administration of tomato juice, orange juice, or potassium chloride relieved those symptoms and the medication was continued (Case Report No. 1). All five patients who discontinued the

CASE REPORT NUMBER 1

Mrs. J.P., w.f. 30—Pregnancy eight mos., excess weight gain and edema

Date	Weight—Lbs.	Observations
Mar. 2	144	
Apr. 3	148	
May 3	153	Begin polythiazide, 1.0 mg. daily.
May 10	150	Adequate diuresis. Weakness within 2 hours. Skipped medication one day—no weakness. Serum Na—136; K—3.9.
May 17	146	Increased polythiazide to 2.0 mg. Add orange juice and tomato juice to diet.
May 24	146	Adequate diuresis. No edema, no weakness.

therapy because of continued weakness reported that the symptoms disappeared within 24 hours. There were no complications of pregnancy attributable to the medication and no dehydration of the newborn was observed at any of these deliveries even though therapy was continued until the onset of labor.

Premenstrual Edema

Polythiazide was administered for ten to 12 days each month to twelve patients with premenstrual edema. Each of these patients complained of premenstrual weight gain of four to ten pounds associated with demonstrable pretibial and pedal edema. An initial dose of 0.5 mg. was given to each patient in an effort to determine diuretic effectiveness and the minimal effective dose (Table III). Adequate diuresis

TABLE III
PREMENSTRUAL EDEMA
(12 Patients)

Polythiazide— Single Daily Dose	Number Patients	Diuresis and Control of Edema	
		Adequate	Inadequate
0.5 mg.	12	2	10
1.0 mg.	11	5	6
2.0 mg.	6	5*	1
4.0 mg.	1	0	1
8.0 mg.	1	1	0

*2 mg. every other day proved adequate in 2 patients

occurred in only two patients who received 0.5 mg. daily and in five of 11 patients who received 1.0 mg. daily. A 2.0 mg. daily dose proved to be adequate for five of the six patients who failed to respond to 1.0 mg. The remaining patient required a dose of 8.0 mg. daily for adequate diuresis. The optimal dose range in this group of patients was from 1.0 to 4.0 mg. with the majority of patients responding adequately to a single daily dose of 2.0 mg. polythiazide. Two patients in this group observed that 2.0 mg. every other day proved adequate to control the edema. The medication was discontinued in two patients because of undesirable symptoms of weakness, nausea, and palpitation. One patient who for years had experienced severe premenstrual breast congestion and painful glandular enlargement of the mammary and axillary glands, was relieved completely of these symptoms. Breast examination a few days before menses in three consecutive months during treatment with polythiazide revealed neither tenderness nor palpable glands. This patient previously had been subjected to monthly evaluation for consideration of breast biopsy.

Determination of Minimal Effective Dose of Polythiazide for Control of Edema in Selected Miscellaneous Disorders

Polythiazide was administered to 62 patients with edema associated with the following miscellaneous disorders:

Menopause, receiving steroid therapy	17 patients
Obesity, adjunctive therapy	21 "
Hypothyroidism, receiving thyroid extract	14 "
Arthritis	4 "
Functional hypoglycemia	1 "
Idiopathic edema	5 "
	62 patients

TABLE IV
DETERMINATION OF MINIMAL EFFECTIVE DOSE OF POLYTHIAZIDE TO CONTROL EDEMA IN MISCELLANEOUS DISORDERS*

Polythiazide— Single Daily Dose	Number Patients	Response	
		Adequate	Inadequate
0.5 mg.	5	0	5
1.0 mg.	20	15	5
2.0 mg.	33	26	7
4.0 mg.	11	11	0
6.0 mg.	1	1	0
8.0 mg.	5	4	1
16.0 mg.	1	1	0

*Menopause, steroid therapy	— 17
Obesity, adjunctive therapy	— 21
Hypothyroidism	— 14
Arthritis	— 4
Functional hypoglycemia	— 1
Idiopathic	— 5
	62 patients

Since the initial dose of 0.5 mg. daily proved ineffective in the first five patients treated, the dosage range was increased to 1.0 mg. to 16.0 mg. as required to obtain adequate diuresis. The minimal effective diuretic dose was found to be 1.0 mg. to 4.0 mg. daily as shown in Table IV. Adequate diuresis was obtained in 15 of 20 patients who received 1.0 mg. daily, and 26 of 33 patients who received 2.0 mg. daily. All seven of the patients who failed to respond to 2.0 mg. daily responded well to 4.0 mg. In one patient the diuretic response was increased when the dose was raised to 6.0 mg., and only one of five patients who received 8.0 mg. failed to diurese adequately. This was the patient with functional hypoglycemia whose symptoms, except for edema, were being controlled by a frequent-feeding high protein diet. A daily dose of 16.0 mg. was given to one hospitalized patient receiving a restricted (750 calorie) diet for initial management of obesity (Case Report No. 2). This dose was used to determine tolerance and effect on serum and urine electrolyte levels. The diuretic effect of this

CASE REPORT NUMBER 2 W.F. 39—Obesity, amenorrhea, edema

Date	Weight Lbs.	Polythiazide Daily Dose	Fluid (CC)		Serum (mEq./L)*		Urine (mEq/24 hrs.)*	
			Intake	Output	Na	K	Na	K
Mar. 19	166	—	1990	1680	142	3.8	200	60
Mar. 20	166	Begin 16.0 mg.	1960	1640	142	3.8	308	65
Mar. 22	162	Begin 16.0 mg.	1940	2640	142	3.8	383	70
Mar. 24	157	Begin 16.0 mg.	1825	2410	141	3.8		
Mar. 26	154	Begin 16.0 mg.	1760	1930	141	3.6	334	68.2
Mar. 28	150	Begin 16.0 mg.	1200	1120	141	3.1		
Mar. 30	149	Reduced to 3.0 mg.	1080	1140	138	3.2	308	65
Mar. 31	149	Reduced to 3.0 mg.	1080	1020	138	3.6		
Apr. 1	148	Reduced to 3.0 mg.	1160	1100	140	3.4	260	62

	<u>Sodium</u>	<u>Potassium</u>
*Based on normal values:	Serum: 138 - 148 mEq/L	3.8 - 5.2 mEq/L
	Urine: 130 - 200 mEq/TV	40 - 65 mEq/TV

UNTOWARD EFFECTS OF THERAPY — NONE

dose was good, but no greater than with a 4.0 mg. dose in the same patient. In this group of patients, as in the pregnancy and premenstrual groups, optimal diuresis was obtained in the majority of patients with a minimal dose of 2.0 mg. to 4.0 mg. once daily. The maximal increase in urinary output occurred during the first three days of therapy (Case Report No. 2). As shown in Table V, twelve (19.6%) of the 62 patients in this group reported undesirable symptoms attributable to the medication. In every instance these symptoms developed within the first two days of treatment. Duration of therapy was ten days to six months in this group of patients. Neither drug resistance nor development of undesirable effects was observed as a result of prolonged use of the drug.

Electrolyte Studies

In 25 selected patients, 19 of whom complained of undesirable symptoms while taking the medication, serum and urinary sodium, potassium, and chloride determinations were obtained. Serum potassium levels ranged from 3.1 mEq/L to 4.9 mEq/L during prolonged therapy with 1.0 mg. to 4.0 mg. of polythiazide daily. The lowest serum potassium level obtained, 3.1 mEq/L, was in the patient who received 16.0 mg. daily (Case No. 2), and this patient experienced no clinical symptoms of hypokalemia. Serum potassium levels were obtained on every patient who exhibited symptoms of weakness, and ranged from 3.4 to 5.4 mEq/L. Seven patients with serum potassium levels below 3.4 mEq/L (3.1 to 3.2) exhibited no untoward symptoms whatsoever. Serum sodium levels remained within normal limits and varied from 133-145 mEq/L throughout treatment.

Twenty-four hour urine volumes varied from 1270 cc. to 2735 cc. during the first three days of treatment. Urinary sodium excretion was increased from the normal range of 130-200 mEq/24 hours before therapy to 308-383 mEq/24 hours during treatment. Urinary potassium excretion increased from 40-65 mEq/24 hours before treatment to 65-70 mEq/24 hours during treatment.

TABLE V
POLYTHIAZIDE
0.5 to 16 mg. daily

Number of Patients	Diuretic Ade-quate	Response		Tolerance	
		Inade-quate	Satis-factory	Satis-factory	Unsatis-factory
Pregnancy	51	51	0	46	5
Premenstrual	12	12	0	10	2
Edema	62	61	1	50	12
Miscellaneous					
125	124	1	106		19

TABLE VI

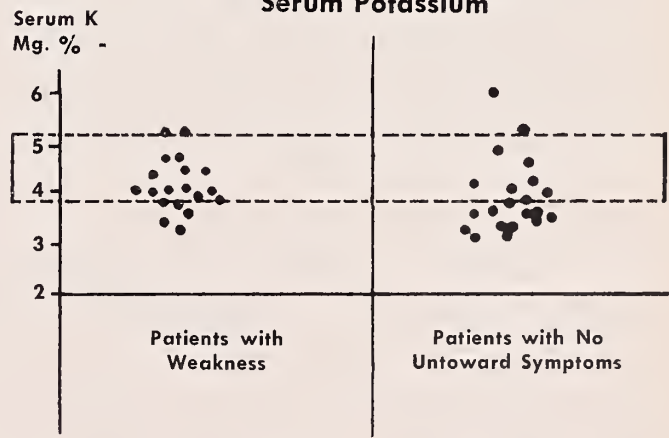
EVALUATION OF POLYTHIAZIDE TOLERANCE IN 125 PATIENTS

Total Number of Patients	125					
Number of Patients with Undesirable Symptoms	19 (15.2%)					
Incidence of Undesirable Symptoms	Dosage					
	0.5 mg.	1.0 mg.	2.0 mg.	4.0 mg.	8.0 mg.	
Weakness and fatigue	17	2	6	5	1	3
Thirst and constipation	15	0	3	10	2	0
Leg cramps	5	0	1	3	1	0
Nausea	4	0	1	2	1	0
Salt craving	4	1	2	1	0	0
Palpitation	2	0	2	0	0	0
Rash	1	0	1	0	0	0

Side Effects

Untoward effects of polythiazide were observed in 19 of the 125 patients studied (Table VI). The most disturbing symptoms were those of weakness and fatigue experienced by 17 patients. Nine of these patients were completely relieved of these symptoms and were able to continue the medication by addition of orange or tomato juice to the diet daily or by administration of potassium chloride (Case Report No. 3). In the remaining eight patients the medication was discontinued because of the severity of the exhaustive type weakness, although there was no evident correlation between the serum potassium levels and the incidence or severity of these symptoms (Table VII). Muscle cramps, usually in the

TABLE VII
Polythiazide (P-2525)
Serum Potassium



legs, were reported by five patients and this symptom was relieved in all five patients by the addition of orange juice to the diet. Mild nausea was reported by four patients, and occasional palpitation by two patients. Undesirable physiological effects of rapid diuresis included thirst and constipation in 15 patients and salt craving in four patients. It is interesting to note that the majority of patients who presented symptoms which appeared to be attributable to hypokalemia had serum potassium levels within normal limits, and that other patients with serum

potassium levels below normal limits had no symptoms. Similarly, there was no apparent correlation between the incidence of side effects and the dosage of polythiazide administered (Table VI). Although symptoms attributable to hypopotassemia, hyponatremia, and hypovolemia occurred, these could not be confirmed by routine laboratory determinations. This suggests the possibility of a physiologic lag between dietary replacement and intracellular to extracellular shift of certain of these electrolytes. Also possible may be a rapid shift of intracellular electrolytes to the serum in the test tube before laboratory determinations.

Summary and Conclusions

One hundred and twenty-five patients with edema of pregnancy (51 patients), the premenstruum (12 patients), and certain miscellaneous conditions (62 patients), were treated with a new thiazide compound, polythiazide (Renese®). The purpose of this study was to determine the minimal effective dose of this compound in each of these conditions. No adjunctive therapy was employed except when specifically required, and no dietary restrictions were advised. The usual dose employed was 0.5 mg. to 4.0 mg. once daily during the morning. A few patients received larger doses up to 16.0 mg. In the pregnancy group the effective dose range was from 1.0 to 4.0 mg. with the majority of patients responding satisfactorily to 2.0 mg. daily. The usual effective dose for premenstrual edema was 1.0 to 2.0 mg. daily, although several patients in each group reported control of edema with a single dose of 2.0 mg. every other day. Onset of diuresis was noted within 45 minutes by

a few patients and within three or four hours by most patients. Duration of effect was from 24 to 48 hours for a single dose. In the miscellaneous group of 62 patients with edema associated with the menopause, obesity, hypothyroidism, arthritis, functional hypoglycemia and idiopathic causes, the effective dose varied from 1.0 to 4.0 mg. with one patient requiring 6.0 mg. and four patients requiring 8.0 mg. daily for adequate control of edema. Undesirable physiological effects of therapy were observed in eighteen of the 125 patients studied. These symptoms included weakness, leg cramps, thirst and constipation, salt craving, nausea, and palpitation. Of these, profound weakness in eight patients was the only disturbing symptom which occurred and this disappeared completely in all patients within 24 hours after they discontinued medication. Mild weakness and fatigue in nine patients was relieved by addition of orange or tomato juice to the diet or by administration of potassium chloride. One patient developed a generalized exfoliative dermatitis after three days of treatment with 1.0 mg. daily. Whether or not this was related to the polythiazide therapy is uncertain; however, the medication was discontinued and the rash disappeared in ten days with corticosteroid therapy. With the exception of those patients (8.0%) who experienced undesirable side effects which were not relieved by potassium containing foods or administration of potassium chloride, patient acceptance of polythiazide was enthusiastic.

From this study it appears that polythiazide, 1.0 to 4.0 mg. once daily, is an effective, relatively safe, oral diuretic for management of edema in pregnancy, the premenstruum, and various other conditions.

1139 Druid Park Avenue

CASE REPORT NUMBER 3

C.F. aged 30; Nephritis at nine years of age; HCVD with congestive failure; Hypothyroidism (surgery for thyrotoxicosis)
Previous therapy: Hydrochlorothiazide, 50 mg. bid
Other medications: Digitalis, thyroid extract, reserpine

Date	Weight		Blood Pressure	Polythiazide Dose	Serum		Urine (24 Hr.)			Side Effects
	Lbs.	Edema			Na	K	Vol.	Na	K	
Mar. 22	244	3+	140/100	1.0 mg.	141	5.3	1220	200	54	—
Apr. 5	241	3+	140/110	2.0 mg.	141	5.1	2365	308	65	None
Apr. 19	242	2+	134/88	3.0 mg.	139	4.1	2735	383	70	None
May 10	241	1+	118/86	4.0 mg.	139	4.1	2400	334	68	None
May 17	239	None	130/88	8.0 mg.	139	3.4	—	—	—	8.0 mg. caused weakness, dizziness, leg pains. Took 40 mg. daily.
May 24	239	3+	130/80	8.0 mg. c KC1 0.5 gm. bid						
May 30	235	None	130/80	8.0 mg.	139	5.4	2100	330	69	None

References

1. Unpublished data. The Medical Department, Pfizer Laboratories Division, Chas. Pfizer & Co., Inc., New York, Feb., 1961.
2. Current Concepts in Therapy: Diuretics, *The New*

England Jour. Med. 264:1204, 1961.

3. Barfield, W. E., Jungck, E. C., and Greenblatt, R.B. : The Use of A New Oral Saluretic Agent in Management of Obstetrical and Gynecological Disorders, 47:604, 1958.
4. Jungck, E. C., Barfield, W. E., and Greenblatt, R. B.: Chlorothiazide and Premenstrual Tension, 169:112, 1959.

1962-63 CALENDAR OF MEETINGS

State

October 23, 1962-March 14, 1963 — Series of Postgraduate Courses presented by the Medical College of Georgia's Department of Continuing Education: December 4-6—"Orthopedics in General Practice"; February 12-14—"Growth and Development—Management of Common Behavior Disturbances."

November 29-30—Fourth Annual Postgraduate Course in Ophthalmology of the Emory University School of Medicine, Grady Memorial Hospital, Atlanta.

December 5—Medical Science Day, Toccoa Clinic, Toccoa.

February 17-20, 1963—Atlanta Graduate Medical Assembly, Atlanta Biltmore Hotel, Atlanta.

May 5-8, 1963—109th Annual Session of the Medical Association of Georgia, Aquarama, Jekyll Island, Georgia.

Regional

November 16-17—Fourth Annual Meeting, Florida State Surgical Division, International College of Surgeons, University of Florida College of Medicine, Gainesville, Fla.

October 1962-November 1963—Fourteen Postgraduate courses offered by the University of Tennessee College of Medicine: February 13-15, 1963—"Emergency Surgery in the Care of the Injured Patient," March 7-8, 1963—"Urinary Tract Diseases—Diagnosis and Treatment."

February 14-16, 1963—American Society of Clinical Pathologists, New Orleans, La.

National

November 24-25—American College of Chest Physicians, Annual Interim Session, Ambassador Hotel, Los Angeles, Calif.

November 25—National Conference on the Medical Aspects of Sports, Statler Hilton Hotel, Los Angeles, Calif.

November 25-28—American Medical Association Clinical Meeting, Los Angeles, Calif.

November 25-30 — Radiological Society of North America, Inc., Palmer House, Chicago, Ill.

November 29-December 2—American Medical Women's Association, Ambassador Hotel, Los Angeles, Calif.

December 1-6—American Academy of Dermatology, Inc., Palmer House, Chicago, Ill.

December 3-5—Association for Research in Ophthalmology, University of Michigan Auditorium, Ann Arbor, Mich.

December 3-7—The Council on Postgraduate Medical Education of the American College of Physicians, "Occupational Diseases of the Heart and Lungs," Statler Hilton Hotel, Detroit, Mich.

December 4-6—Southern Surgical Association, Boca Raton Hotel, Boca Raton, Fla.

December 7-9—American Psychoanalytic Association, Commodore Hotel, New York City.

January 18, 1963—American Society of Facial Plastic Surgery, Hotel Elysee, New York City.

February 6-9, 1963—American College of Radiology, Drake Hotel, Chicago, Ill.

February 7-9, 1963—Society of University Surgeons, Seattle, Wash.

February 28-March 3, 1963—College of American Pathologists, Rice Hotel, Houston, Tex.

February 28-March 4, 1963—American College of Cardiology, Ambassador Hotel, Los Angeles, Calif.

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**Whatever happened
to handkerchiefs?**

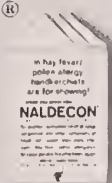


Remember when handkerchiefs were used for stuffy or runny noses? *That was before Naldecon.* Naldecon lets your head-cold patient breathe the way he should. Through the nose. Honest relief that lasts up to 8 hours with one sustained-action tablet. (When you need it, even *half* a tablet retains the sustained-action feature.) The counterbalance between *two* antihistamines and *two* decongestants* usually gives excellent results—seldom causes overstimulation or sedation. Keep handkerchiefs for showing. Prescribe Naldecon.

*Each tablet contains phenylephrine HCl 10 mg., phenylpropanolamine HCl 40 mg., phenyltoloxamine citrate 15 mg., chlorpheniramine maleate 5 mg.—half in the outer layer, half in the sustained-action core. Each teaspoonful (5 cc.) of Naldecon Syrup contains the equivalent of one-half tablet.

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How well are we telling our story?

To a large degree the ability of the medical profession to be heard in the legislative halls of the nation is directly related to the extent to which the profession's views are shared by the public-at-large. To increase public understanding and acceptance of policy positions enunciated by the profession we must make our position known to the lay public. Regardless of the subject, be it medical, social or political, when physicians address lay audiences, "grass roots" support for the profession is enhanced. Here is a pictorial illustration of how well we are telling our story to the public.



NEW PKU MOTION PICTURE PREMIERED AT UNIVERSITY OF WISCONSIN

A new medical motion picture, "PKU Mental Deficiency Can Be Prevented" was shown for the first time to physicians at a special premiere at the University of Wisconsin, recently.

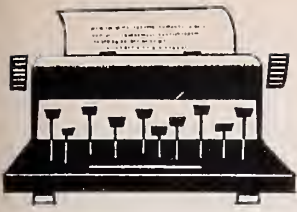
The film was produced under the supervision of Dr. Harry A. Waisman of the University of Wisconsin Medical School's Department of Pediatrics. It presents the case histories of two siblings, both with phenylketonuria (PKU)—an inborn metabolic error, which can lead to severe and permanent mental retardation. One child was treated soon after birth and the older child was diagnosed too late.

The film reviews the biochemistry, genetics, symp-

toms, diagnosis and management of PKU. A number of simple diagnostic tests are described by Dr. Waisman, including Phenistix (stick test), ferric chloride, 2-4 dinitrophenylhydrazine, bacterial inhibition, and quantitative plasma analysis.

Testing for PKU, the film stresses, must become as routine and as standard for general practitioners and pediatricians as shots for DPT, polio, and smallpox.

The 14½ minute, sound, black and white motion picture is available for showings, without charge, to medical groups and organizations. Requests for prints should be sent to the Medical Film Department, Ames Company, Inc., Elkhart, Indiana.



The Basis for the 1962 A₂ Influenza Prediction

FOR ANY GIVEN YEAR, an influenza prediction is based upon the answers to two broad questions. The first is concerned with whether or not influenza will occur in widespread epidemic proportions. The second is concerned with an identification of the virus strain most likely to be responsible for a predicted epidemic. Answers to these questions involve close cooperation between clinician, epidemiologist and virologist, and provide the bases for Public Health action and vaccine recommendations.

An important guideline for the prediction of widespread outbreaks is the apparent periodicity in the occurrence of influenza epidemics. As early as 1918, workers in Great Britain speculated on the evident periodic pattern in epidemics occurring subsequent to 1889 in that country. Similar observations were made in this country, but until the discovery of types A and B influenza viruses in the early 1930's, hypotheses for predicting influenza did not have more than short term success. The ability to assign outbreaks to the influenza A or B etiologic categories which followed the original discovery of these viruses led workers in 1941 to observe a two-year periodicity for epidemics due to virus A and to suggest a four-year periodicity for influenza B. The occurrence of influenza epidemics during the last 20 years in the United States has served to confirm the impression that there is a differential periodicity between influenza A and influenza B occurrence and that major outbreaks due to influenza A occur every two to three years. Epidemics attributed to the A₂ Asian virus isolated first in 1957 have followed this pattern. Since the last widespread outbreaks attributed to influenza A virus occurred during the winter of 1959-60, the likelihood of occurrence of an epidemic during the 1962-63 winter season is especially great.

The identification of the virus strain most likely to be responsible for the predicted epidemic is based partly on the observation that sporadic outcroppings of influenza due to the predicted virus type tend to occur with increasing frequency during the spring

and summer months prior to a winter epidemic period. Laboratory surveillance of these disease occurrences enables the virologist to measure with some certainty the antigenic characteristics of the prevalent virus strain.

The Communicable Disease Center, operating the International Influenza Center for the Americas as part of the World Health Organization influenza program, provides this laboratory surveillance of sporadic disease as well as surveillance of major outbreaks through a network of seventy-five laboratories located in this country and in most countries of the Western Hemisphere. Close cooperation with the World Influenza Center in London, which has a similar network of laboratories in the Eastern Hemisphere places this surveillance on a worldwide base. Type A and B influenza viruses undergo continuous antigenic variation through the years, and the studies of the antigenic constitution of the viruses undertaken in these laboratories, enables the detection of minor as well as major variations.

Type A₂ influenza viruses have been isolated during the early spring and summer of 1962 in this country and elsewhere, and antigenic studies of these viruses indicates that, although there has been a minor antigenic change in them, there is still a close relationship to the 1957 strains.

This characterization of the more recently isolated strains has led to the approval of the antigenic composition of currently available vaccines. Vaccination with these vaccines should offer ample protection against infection by the viruses most recently isolated from cases of the disease, and thus be of value in combating the coming outbreaks.

*James E. Maynard, M.D.
Chief, Influenza Surveillance Unit
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Is That So ?? No !!

THE OLD KING-ANDERSON BILL IS DEAD. Is that so? No! True, the form of this bill which was presented to the Senate was defeated on July 17, 1962, but it is a long way from being dead. The ones who have planned this bill are continuing to work and strive to build up political prestige for its passage. In all manners and methods they are working to bring it back again at the very next opportunity, at which time they think it will be successful.

The Ground Work

There has been considerable "ground work" done in building up this type of legislation over a period of years. This is one of the many ways by which this group hopes and works to increase the "Socialist trend" in America. Too often members of the medical profession say, "The bill is dead. What is there to do at the present time to combat this type legislation?" Here's what you can do:

1) Consider, as usual, the welfare of your patients. See that none are denied proper medical care, and continue to work toward improving medical care in your community and area.

2) Join GaMPAC and, consequently, AMPAC,

and encourage others to do likewise. (This allows an organized, systematic candidate evaluation on a local as well as a national level.) Encourage registration and voting in your area after the issues have been presented.

3) Talk up the advantages of free enterprise, medical practice free of political control, and the rights of the individual, not only to small groups, civic groups, and other lay groups, but in any place you can. If you feel you had rather have someone from the outside to do it, contact the MAG or GaMPAC, and they will be glad to furnish you speakers.

4) Demonstrate and explain that fundamentally what you are standing for is the basic structure of the country. If the medical profession is undermined and socialized, the other professions and organizations will soon follow.

So if anyone tells you that Socialized Medicine is dead, just say, "Is that so? No!"—and tell them how to keep working to prevent passage of this type legislation.

*Milford B. Hatcher, M.D.
Chairman, GaMPAC*

Athletics, Physicians, and Athletes

SPORTS, LIKE MEDICINE, is one of the last bastions of daily life which stresses excellence rather than mediocrity. In sports an athlete reaps according to his work; there is no welfare program. Let us do our part toward holding up this wonderful and stimulating part of their education. It is wonderful

to see our youths being taught through sports to strive for quality.

Physicians have the community responsibility of being sufficiently interested in the health of the athlete so that every varsity high school game should be covered by a physician on the bench, available

to go on the field enthusiastically, to see an injury, at the request of the coach or official. This presence probably comforts the parents and all other spectators more than it comforts the downed athlete. The coach and official are thus relieved of unwarranted medical responsibility. The physician thus minimizes public antagonism due to injuries. Also, from a public relations standpoint, this contribution to sports and athletes can be one of medicine's finest hours.

The Memory

Few spectators will remember the name of the doctor who went on the field to help, most will remember a doctor did go on the field to help, and everyone will remember if no doctor was available to go on the field to help!

Furthermore, those of us participating as team physicians should every few years avail ourselves of the opportunity to attend a conference on sports medicine to keep up to date with advances. A coach, attending these conferences, cannot help but observe a lot of tricks of examination and diagnosis; he will be unconsciously and uncritically observing his team physician during his diagnosis of these in-

juries. The interested and learning coach will soon know if his team physician has been attending such meetings, reading, and generally keeping abreast of the developments related to The Medical Aspects of Sports. Really, it would be ideal for the physician and coach of a team to attend the meeting together. This helps them to be closer to one another in discussing and solving the athletic problems of the community in the future.

Those of you receiving such an invitation to the Third Georgia Conference on The Medical Aspects of Sports are urged to attend and bring your coach.

A Great Loss

If physician interest and participation in the forthcoming Georgia Conference on The Medical Aspects of Sports proves insufficient, this post-graduate course should probably be discontinued, as it may produce discord to have the coaches overly alerted to recent advances. A great loss will then be incurred by all of those associated with sporting activities.

Jack C. Hughston, M.D.

**AUDIO-DIGEST FOUNDATION
ANNOUNCES OPHTHALMOLOGY ADDITION**

The Audio-Digest Foundation—a nonprofit subsidiary of the California Medical Association—announces this week the possible addition of Ophthalmology to their present group of subscription tape recordings. Audio-Digest recordings, over the past ten years, have become popular means of “keeping up” in six other areas of medical practice: General Practice, Surgery, Internal Medicine, Obstetrics-Gynecology, Pediatrics, and Anesthesiology. More than 30,000 recordings are mailed to all parts of the world each month.

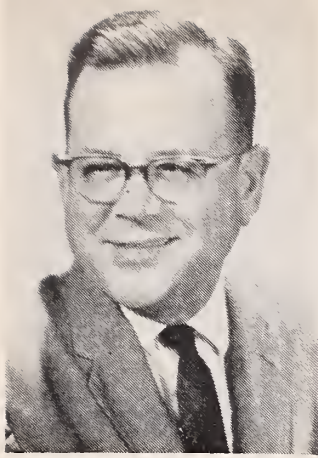
According to the Foundation's Board of Trustees, the exact commencement date of Audio-Digest Ophthalmology depends upon how many pre-enrolled subscribers are obtained between now and early 1963. It is intended that the tapes will be issued twice each month. If sufficient interest is indicated from Otorhinolaryngologists, as well as Ophthalmologists, one tape a month will be devoted solely to the eye and the other tape devoted exclusively to ear, nose, and throat.

Interested specialists are invited to indicate their subscription choice by writing for further information from Editor C. L. Oakley, 619 S. Westlake Ave., Los Angeles 57, Calif.

**ACTIVE DUES EXEMPT AND ASSOCIATE
MEMBERS ELIGIBLE FOR HALF RATES**

In order to encourage AMA dues exempt and AMA associate members to continue or order new subscriptions for the AMA periodicals, both *active dues exempt* and *associate* members are now eligible for the 50 per cent subscription rates. The regular and 50 per cent rates for AMA periodicals for 1963 are listed below:

Name of Periodical	Regular Rates (U.S. Poss. & Canada)		Special 50% Rates (U.S. Poss. & Canada)	
	1 Yr.	2 Yrs.	1 yr.	2 yrs.
Journal A.M.A.	\$18.00	\$27.00	\$9.00	\$13.50
A.M.A. News (Free)				
Today's Health	4.00	6.00	2.00	3.00
Amer. Jr. of Dis. of Child	12.00	18.00	6.00	9.00
Arch. of Dermatology	12.00	18.00	6.00	9.00
Arch. of Environmental Health	12.00	18.00	6.00	9.00
Arch. of General Psychiatry	12.00	18.00	6.00	9.00
Arch. of Internal Medicine	12.00	18.00	6.00	9.00
Arch. of Neurology	12.00	18.00	6.00	9.00
Arch. of Ophthalmology	12.00	18.00	6.00	9.00
Arch. of Otolaryngology	12.00	18.00	6.00	9.00
Arch. of Pathology	12.00	18.00	6.00	9.00
Arch. of Surgery	12.00	18.00	6.00	9.00



PRESIDENT'S LETTER

"LEARN NOW — PAY LATER"

TELEVISION PERSONALITY Jackie Gleason once said that "the best way to waste money is to keep it." This was not an admonition against savings, but rather against permitting money to lie idle, gathering dust. Idle money does no one any good, whereas invested money fulfills a high and beneficial purpose.

Such an investment tailored for physicians now exists. The loan guarantee program of the AMA's Educational and Research Foundation is one of the best examples of good money well invested that has come to my attention in a long time.

Fund Result of Rising Costs

The loan guarantee fund, now in its ninth month of operation, came about as a direct result of the rising cost of a medical education. To meet this rising cost, the Directors of the American Medical Association Education and Research Foundation arranged a loan program for medical students, interns and residents, that will permit them to learn now and pay later.

There are now approximately 55,000 medical students, interns and residents in training to become physicians. As one can easily imagine, the majority of these are feeling the pinch of steadily rising costs in medical training. Of course, there's nothing new about a medical student's being in financial straits. Many of us can well recall our own money problems during student days and as interns and residents. The big difference is that the problem is getting bigger and reaching unmanageable proportions.

This is where the loan guarantee fund comes into the picture. The purpose of the fund is to guarantee commercial bank loans at low interest rates, repayable after the student completes his training and goes into practice.

Through arrangements made by the AMA, bank loans equal to 12½ times the amount of the guarantee fund are now being made to students, interns and residents with which to complete their training. In other words, for every \$1.00 on deposit in the guarantee fund, the banking industry will lend

\$12.50. As loans are paid off, when students begin their practice, this fund will become self-sustaining and there will no longer be a need for contributions.

To date more than 700,000 tax deductible dollars have been contributed to this fund by physicians interested in this worthy program. It is a bold and farsighted answer to the increasing sentiment for a government take-over in the financing of medical education. It represents a major breakthrough for American medicine and demonstrates once again that a free society will always find ways of fulfilling its capabilities and its desires.

Since February of this year over \$7 million worth of bank loans has been made to qualified students under the loan guarantee program. Medical students in 49 States representing 81 schools and interns and residents in 320 hospitals have benefited by this program.

The future of the medical profession will be determined by the number and quality of the men and women who undergo medical training. We owe it to ourselves, and more importantly we owe it to the profession, to make certain that no qualified student, intern, or resident turns away from medicine for the lack of money. We must meet this need or the future of medical education is in trouble. The Federal Government is waiting ominously in the wings and should free enterprise fail, it will move, as it must, to fill the vacuum.

Dynamic Program

The loan guarantee fund is a dynamic program, boldly conceived and soundly administered. I urge every doctor in Georgia to contribute generously to this fund, not only as insurance against the possibility of excessive Federal intrusion, but as a good investment in the future of the medical profession itself.

Checks should be made payable to the AMA Education and Research Foundation and mailed to 535 North Dearborn Street, Chicago 10, Illinois. Do it today. Remember it's tax deductible, but more important, it is just a good investment.



THE INTERNALIZING AND EXTERNALIZING PATIENT

Arthur Burton, Ph.D., *San Jose, California*

THERE ARE TWO WAYS of approaching one's personal world. One can look inwardly to the body and to the thought processes, or one can look outwardly to the environment. There is some evidence that people characteristically do one or the other, and we have called such people internalizers and externalizers, respectively.

It makes a difference whether you believe your fate lies within you, or outside of you. In the one instance reflection, bodily sensations, and feelings of one kind or another govern; in the other, action replaces reflection. Thus the neurotic patient solves things by the mental manipulation of ideas which may not have a counterpart in reality. The so-called sociopath or psychopath, on the other hand, lives his problems immediately and directly by action involving people or objects. This is more than merely being introvertive or extrovertive, for one's entire style of life is based upon the need to either "take things in" or "spill them out," and so become character-sets of the person.

Extremes of Orientation

Neurotic and sociopathic patients are, however, but the extremes of basic ways of orienting oneself toward the total world. One can internalize or externalize in lesser degrees than the neurotic or sociopath, and only if the orientation is carried beyond the limits of accepted normality are such clinical designations helpful. Thus it is often said that there is a little of the neurotic or sociopath in all of us, meaning, of course, that the tendency to internalize or to externalize is universal. Successful businessmen are often externalizers, whereas the artist finds most inspiration from within himself.

A Balance

Being normal calls for an Internal/External balance. Obviously, one who speculates all the time

without ever acting is as bad off as one who acts without ever speculating. A normal person tempers action with reflection, and vice versa. Sometimes it is possible to complete one's Internal/External balance by complimentary representation in another person. Thus, an internalizer may marry an externalizer, or he may write a novel in which he externalizes himself through the hero of the novel. A person is under constant pressure to express himself according to his primary mode, but also to find a balance through its direct opposite. That is, internalizers want to be externalizers, and per contra.

Internalizer Preferable

Psychiatry prefers to treat the internalizer and is most effective with this kind of person. The treatment takes place in the physician's office, is more or less passive, and language and symbols are the medium of the transaction. The patient is expected to show a certain docility (suggestion, persuasion, etc.), to develop a deep rapport, and to emulate the therapist in some respects in the final goal of adjustment. The patient verbalizes rather than acts out his conflicts.

For these reasons, neurotics make the best patients, whereas alcoholics, drug addicts, sexual deviates, and the anti-social do not. This is not to say that the latter cannot be treated, but that present models of psychotherapy are less successful with externalizers. This is possibly because we know less about them, but also because they are more troublesome. Neurotics grow in treatment from their inner core to the outside environment; but it is more difficult to reverse the procedure with the externalizers.

In your practice you will meet both mild and severe internalizers and externalizers. Neither is a cause for pessimism. It is wise to study the patient for his principle mode of balance, and to approach him in his characteristic way without necessarily

playing into any pathology. Rapport will be furthered in this way, for the patient will feel that you understand him in a fundamental way.

Medical instructions or interpretations given to internalizers will be the subject of considerable and often obsessive rumination, and they usually have to be made carefully. They will respond to the "parent" status of the physician with appropriate attitudes of benevolent expectation; the externalizers

sometimes respond with superficial acceptance, or concealed or ill-concealed hostility. The former reacts to the personality of the physician; the externalizer to his prescription or to the doctor's manipulation. Above all, the internalizer, always aware of his body, will tend to magnify (or diminish as a counter-reaction) the impulses and feelings coming from his body, and he will present himself to you for treatment with greater frequency and be more insistent about his complaints. The externalizer, on the other hand, will be more anxious about his car, his money, and possibly his wife.

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

A BACKWARD GLANCE AT MEDICAL LEGISLATION

Amid the confusion caused by the threatened enactment of the King-Anderson bill, many bills of interest and concern were overlooked by the rank and file of the profession during the now concluded 87th Congress.

Understandably the drama of the King-Anderson fight held center stage throughout the two year life of the 87th. Nonetheless, legislation of considerable importance to the profession was introduced, debated and enacted. The following is a brief descriptive summary of some of these important pieces of legislation.

H.R. 10606. This is a bill, now Public Law 87-543, which permits the unification of certain State administered welfare programs. Specifically it provides for States to operate public assistance plans for the aged, blind, disabled and Kerr-Mills Medical Assistance for the Aged programs as a single unit. This unification, favored by AMA permits greater efficiency in administration and hence improved benefits accrue to recipients. In addition the matching formula results in increased money available for the aid to the blind and disabled programs.

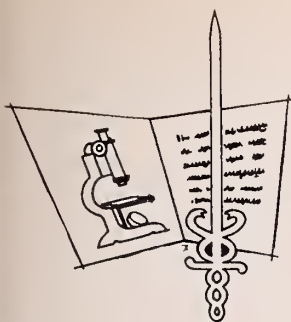
H.R. 10620. This bill would roughly double the maximum amounts an individual may claim on his income tax return for medical and dental expenses as a deduction. This bill was amended on the floor to include the language of the Curtis Bill, H.R. 10117, which permits corporations to include health insurance for retired persons as part of a tax deductible and pension plan.

Both of these bills taken together will help to take some of the wind out of the sails of those advocating greater government participation (King-Anderson type legislation) in medical care programs for the aged.

H.R. 10541. This bill authorizes a \$36 million, three-year program of Federal aid to state for the purpose of intensifying their vaccination programs against polio, diphtheria, whooping cough and tetanus. The vaccination campaigns are aimed primarily at children under five years of age. However, it is not limited in this regard.

H.R. 11581. The Drug Control Bill, perfected in a House-Senate Conference Committee made the following provisions: (a) manufacturers must prove efficacy as well as safety; (b) FDA given broader authority to inspect manufacturers' records and factories; (c) require drug advertisements to summarize side effects; (d) require consent of patient before M.D. can give experimental drugs, unless not feasible or not in best interest of patient; (e) require certification of batch testing on antibiotics for human consumption; and, (f) require new drugs be tested on animals before given to humans in clinical investigations.

H.R. 10. This is the bill to provide tax relief for self-employed individuals seeking to set up retirement programs. Enactment of this bill culminated a 12 year effort on the part of AMA and others to obtain passage of legislation of this type.



CANCER OF THE THYROID

A. H. Letton, M.D., *Atlanta*

IN THE LAST SEVERAL YEARS we have seen more neglected carcinomas of the thyroid than we have in previous years. There seems to be an increasing lethargy on the part of some physicians concerning thyroid tumors, which I believe to be the natural consequence of the usual experience of the usual practitioner who sees the occasional thyroid problem. This physician in the past has conscientiously either operated on or caused the patient to be operated on for a benign nodule which is causing no trouble. After several cases of finding benign tumors he loses his fear of the nodular goiters, overlooking the fact that one must see a number of benign nodules before a cancerous one is found, since statistically, cancer of the thyroid occurs in four to 25 per cent (depending on the type) of nodular goiters.

Palpation Insufficient

The main problem in handling nodular goiters is that the diagnosis of cancer of the thyroid cannot be made either positively or negatively by palpation of the gland alone (except in the advanced case), and especially by one who feels only an occasional nodular goiter. A physician who feels nodular goiters every day finds it impossible to make better than 50 per cent correct diagnoses.

Other Means

We must, therefore, avail ourselves of other means of diagnosis. Unfortunately, the usual tests of thyroid activity are not of conclusive help. The BMR, the PBI, cholesterol and even the radioactive iodine up-

take are of little help in the diagnosis of malignancy—except that the nodule which contains cancer does not produce hyperthyroidism, and, therefore, cancer should be suspected even more in the patient in whom these tests are normal. The radioactive iodine scan is of most help, yet it, too, is really not diagnostic. Cancer can pretty well be ruled out if the scan of a nodular goiter shows activity in the nodule, but if there is no activity in the nodule, the area is not taking up iodine and not acting as normal thyroid tissue. This then indicates that the area represents either a benign cyst, a benign tumor, or a cancer; and when one comes down to it, any of these three conditions warrant surgery. The cyst and benign tumor will both certainly enlarge and cause pressure symptoms, or cosmetic blemish, and will require surgery in the long run. With these facts in mind, we find that by use of radioactive iodine scan of the thyroid, we can rule out the nodules which will not require surgery and can determine the benign and malignant conditions which will require surgery.

Poor Advice

No patient should be told, "Don't bother that nodule until it bothers you," without first having a scan of the gland. It is true that there are not as many cancers of the thyroid as some other cancers, but this is a disease usually very curable in its early stages that is being neglected, causing too many needless miserable deaths. Let us use the armamentarium that our research has provided, and prevent all the suffering and deaths possible.

Approved by the Professional Education Committee, Georgia Division, ACS.



PREGNANCY AND HYPERTENSIVE VASCULAR DISEASE

Joseph R. Swartwout, M.D., *Atlanta*

PRE-ECLAMPSIA, ECLAMPSIA, despite being largely a preventable disease, is still one of the leading causes of maternal death and contributing causes of fetal death. Much has been said about the treatment of the disease once it has happened, but by far the most important medical contribution is prevention of this serious complication. Prevention is accomplished by: (1) Frequent and adequate observation of all pregnant patients; the disease can develop rapidly and the early warning signs must not be overlooked. (2) Rigid control of weight gain; this includes both caloric gain and salt and water retention. Our standards of allowable weight gain should be revised downward and perhaps the upper limit of total weight gain should be twenty pounds. (3) Prompt treatment when any of the prodromal signs appear. When we consider that eclampsia has the same mortality rate as myocardial infarction in males under 60 years of age, then the early warning signs of this disease (edema, rising blood pressure, albuminuria, rapid or excess weight gain) take on a new importance.

Diagnosis of the Curable

One of the most important considerations of the types of hypertension not etiologically related to pregnancy is to diagnose those that are curable, particularly at a stage of the disease process before irreversible changes have occurred. When pregnancy increases or hastens the effects of the particular hypertension, then we cannot wait until pregnancy is completed before diagnosing or treating the disease. Examples of this are pheochromocytoma and certain types of obstruction of renal blood flow. An exception to this is coarctation of the aorta which should not be repaired during pregnancy due to the changes in the arterial wall.

Essential hypertension is not as frequently associated with pre-eclampsia as was once thought. The

late pregnancy rise in blood pressure is frequently preceded by an early pregnancy drop in blood pressure. The latter may not be observed if the patient does not come early for antepartum care. With good prenatal care and, occasionally, the judicious use of hypotensive drugs, the patient with essential hypertension can safely complete pregnancy. Weight control is important. Since many of these patients are very obese, even weight reduction may be indicated. In the patient who weighs over two hundred pounds, gradual weight reduction during pregnancy can be accomplished safely, providing vitamin and protein intake is adequate. In treating obese patients, it should be remembered that a large arm may give a blood pressure reading that is higher than actual blood pressure. This is most important when evaluating the response to hypotensive drugs.

Renal Hypertension

There is another aspect of pregnancy and hypertension that is not frequently considered. Renal hypertension due to chronic pyelonephritis causes the death of women usually in the fifth decade of life. This disease process is a slow one, taking perhaps ten or 15 years before the terminal stage is reached. For a long period of time, the disease process can be halted before renal hypertension has occurred. During this time the woman is having her children and is being seen by a physician for obstetrical care. Pregnancy predisposes the woman to urinary tract infections, and some obstetrical practices introduce bacteria into the urinary tract causing the disease. Pregnancy, though frequently related to the onset of the disease, may coincidentally occur in a woman who already has asymptomatic pyelonephritis. Three phases of this disease exist in pregnancy: pre-existing asymptomatic chronic pyelonephritis, chronic pyelonephritis with acute exacerbations, and acute pye-

lonephritis that becomes chronic. The colony count culture technique offers the best way for discovering asymptomatic cases and for the one to two year follow-up that acute pyelonephritis demands.

Curable Disease

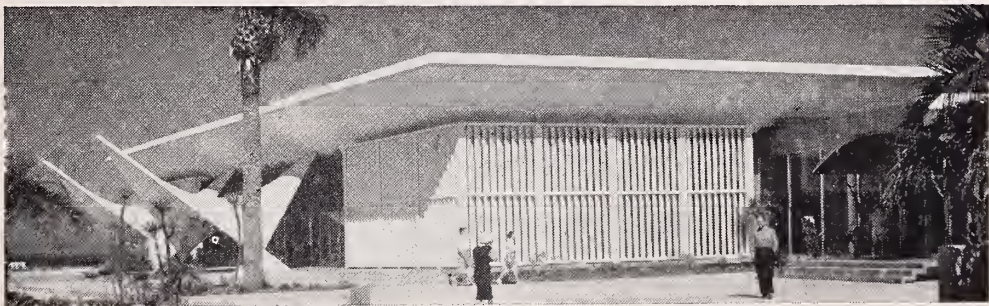
It is well to emphasize again that chronic pyelonephritis is usually a curable disease at the time a woman is having her children and, if not cured, some of these women will die of renal hypertension before their children are grown. The words "cystitis and "pyelitis" should be condemned because they sound benign and because infection of the urinary tract is

rarely localized when there is stasis. All urinary tract infections are serious and demand adequate treatment and follow-up.

Two general observations about hypertension should be made. When hypotensive drugs are used in a patient with hypertension of long duration, care must be taken not to bring the pressure down to "normal levels," for this may be a situation of relative shock for that patient. Also, if any type of shock occurs in a hypertensive patient, corrective procedures must not be stopped when the blood pressure reaches "normal levels," but must be continued until the patient is clinically out of shock.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

Don't Let Another Day Go By!



AQUARAMA, JEKYLL ISLAND, GEORGIA

Plan now to attend the 109th Annual Session

of the

MEDICAL ASSOCIATION OF GEORGIA

May 5-8, 1963

Jekyll Island, Georgia



THE GOOD SAMARITAN

John L. Moore, Jr., *Atlanta*

THE STORY OF THE Good Samaritan is found in St. Luke 10:30-35:

"A certain man went down from Jerusalem to Jericho, and fell among thieves, which stripped him of his raiment, and wounded him, and departed, leaving him half dead.

"And by chance there came down a certain priest that way; and when he saw him, he passed by on the other side.

"And likewise a Levite, when he was at the place, came and looked on him, and passed by on the other side.

"But a certain Samaritan, as he journeyed, came where he was, and when he saw him, he had compassion on him, and went to him, and bound up his wounds, pouring in oil and wine, and set him on his own beast, and brought him to an inn, and took care of him.

"And on the morrow when he departed, he took out two pence, and gave them to the host, and said unto him, Take care of him; and whatsoever thou spendest more, when I come again, I will repay thee."

Principles Developed

Through the development of common law in Anglo-Saxon jurisdiction, principles developed which would say the following. Neither the priest nor the Levite is liable to the man who fell among thieves in any way. There is no duty to help someone. One can stand by and watch a swimmer drown and not take any risk whatever by trying to save him. There are special statutes requiring motorists who have been involved in an accident to render aid to those injured whether or not they were at fault for the accident.

However, the Good Samaritan, especially if he were a professional person who should know how

to give medical assistance, under our law, might well be held liable for failure to place the man who fell among thieves in the hospital instead of the inn. Or, the Good Samaritan might be liable for not using the most modern technique available to specialists on the side of the road when caring for the man who fell among thieves.

Serious Situation

This situation has become quite serious, and concern was expressed throughout the United States that medical doctors would increasingly fear stopping to render assistance at the edge of the highway after an accident because of possible liability. Consequently, bills were introduced in many of the Legislatures, and passed in most, giving some relief from the rather extreme rules of Anglo-Saxon law. In Georgia, such a statute was passed in the 1962 General Assembly (Regular Session). The statute is quite short and reads in full as follows:

"Any person, including those licensed to practice medicine and surgery pursuant to the provisions of Chapter 84-9 of the Code of Georgia of 1933 and including any person licensed to render services ancillary thereto, who in good faith renders emergency care at the scene of an accident or emergency to the victim or victims thereof without making any charge therefor, shall not be liable for any civil damages as a result of any act or omission by such person in rendering the emergency care or as a result of any act or failure to act to provide or arrange for further medical treatment or care for the injured person."

Georgia Doctor Not Liable

In Georgia, therefore, a medical doctor who stops at the scene of an accident to help the injured

persons and who makes no charge is not liable even if he fails to make further arrangements for care or if his treatment does not conform to the highest standards of practice. However, it appears to the undersigned that the words "in good faith" would probably be construed by a court to mean that a medical doctor guilty of gross negligence in the treatment did not render the care "in good faith."

Bar Journal Criticizes

The 1962 Act has been criticized in an article in a recent issue of the Georgia Bar Journal. The writer of the article does agree that the 1962 Act offers a progressive step in seeking to encourage competent parties to render aid. However, the writer doubts that this will cause more persons to stop at the scenes of accidents. He also points out that persons involved in a collision are already under a statutory duty to take positive action to render comprehensive aid. However, this statutory duty would not apply to a medical doctor passing by who had not been involved in the accident. The writer also doubts the practical aid given by the 1962 Act because the services have to be rendered gratuitously. The writer suggests that the medical doctor can simply wait and see if no complications arise and then seek com-

pensation. It seems to the undersigned that the writer of the article misses the point of the doctor-patient relationship. It is hard for the undersigned to see that any situation will arise in which it will not be clear from the outset either that the doctor will charge or not charge. If the doctor merely renders first aid and does not give any follow-up suggestions, care or treatment, it will certainly be assumed by everyone who understands the doctor-patient relationship that the service was gratuitous. Naturally, the doctor who, despite this comment, sends a bill for his services at the side of the road may possibly ask for trouble.

Legislative Attempts

The writer of the article in the Georgia Bar Journal cites legislative attempts in the Vichy government, in the Soviet Union, and in Holland, to impose an affirmative duty for anyone to help another who has been injured, with criminal sanctions on failure to do so if to help would not involve risk to the rescuer. However, this position seems inconsistent with Anglo-Saxon law as it is developed, and it seems to the undersigned that the affirmative relief of those who might fall into the trap of the Good Samaritan under our laws is a better approach.

Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

PFIZER LABORATORIES ANNOUNCES NEW MEDICAL SCHOLARSHIP PROGRAM

A new medical scholarship program which will provide each school of medicine in the United States with a one thousand dollar scholarship beginning with the 1962-63 school year, has been established by Pfizer Laboratories, division of Charles Pfizer & Co., Inc.

In announcing the program, Dr. Roberts M. Rees, Medical Director for Pfizer Laboratories, said the scholarships will be administered solely by the dean of each medical school, or by a committee established by him.

Selection may be made on the basis of academic record, financial need, or other criteria which will be determined by the medical school. The scholarships are designed primarily to apply toward academic and subsistence expenses of one student in each of the 87 medical schools in the United States.

SURPLUS FUNDS SERVE AS STOP GAPS

Surplus funds in the amount of \$100,000 have been consigned to the State Aid Cancer Program as an emergency stop-gap measure to carry the program through the balance of the current fiscal year. The present fiscal year ended on June 30, 1962. Beginning with the succeeding budget year, Georgia's State Aid Cancer Program will revert back to its yearly allocation of \$400,000.

It is apparent from the action taken by the State Board of Health that unless additional money is made available beginning with the fiscal year 1963, Georgia's State Aid Cancer Program will be severely damaged. Either the imposition of more stringent requirements for admission to the program, or serious curtailment of services offered will be the inevitable consequences unless finances can be brought to par with the needs of the program. Either such alternative would be a tragic loss to the health of the people of Georgia.



BOOKS RECEIVED

Forster, Francis M., M.D., *SYNOPSIS OF NEUROLOGY*, The C. V. Mosby Co., St. Louis, Mo., 1962, 223 pp., \$6.75.

Stetler, C. Joseph, LL.B. and Moritz, Alan R., *DOCTOR AND PATIENT AND THE LAW*, The C. V. Mosby Co., St. Louis, Mo., 1962, 529 pp., \$14.75.

Bauer, John D., M.D.; Toro, Gelson, Ph.D.; and Ackermann, Philip G., Ph.D., *BRAY'S CLINICAL LABORATORY METHODS*, Sixth Edition, The C. V. Mosby Co., St. Louis, Mo., 1962, 594 pp., \$10.50.

Williams, Roger J., *NUTRITION IN A NUTSHELL*, Doubleday & Co., New York, N. Y., 1962, 171 pp., \$95.

CIBA Foundation Symposium on *PULMONARY STRUCTURE AND FUNCTION*, Little, Brown and Co., Boston, 1962, 403 pp., \$11.50.

CIBA Foundation Colloquia on Endocrinology Volume XIV *IMMUNOASSAY OF HORMONES*, Little, Brown and Co., Boston, 1962, 419 pp., \$10.75.

Edited by Felix Marti-Ibanez, M.D., *THE EPIC OF MEDICINE*, Clarkson N. Potter, Inc., New York, N. Y., 1962, 294 pp., \$12.50 pre-Christmas; \$15.00 thereafter.

Members of the staff of the Lahey Clinic, Boston; *SURGICAL PRACTICE OF THE LAHEY CLINIC*, W. B. Saunders Co., Philadelphia and London, 1962, 872 pp., \$17.00.

Spencer, H., M.D., *PATHOLOGY OF THE LUNG (Excluding Pulmonary Tuberculosis)*, The Macmillan Co., New York, N.Y., 1962, 850 pp., \$30.00.

REVIEWS

Artusio, Joseph F., Jr., M.D., and Mazzia, Valentino, D.B., M.D., *PRACTICAL ANESTHESIOLOGY*, The C. V. Mosby Co., St. Louis, 1962, 318 pp., \$7.75.

THE PURPOSE OF THIS BOOK, as stated in the preface, is to serve as a true and simple guide for medical students, general practitioners, and other neophyte or occasional anesthetists. As such, it is an excellent handbook of current ideas and practices in anesthesiology.

It is remarkable, in my opinion, how well the authors have made efficient and judicious use of words: Every sentence of the text is virtually loaded with significant information, and yet the book takes the narrative form and is much more readable and pleasant to use than if it were in an itemized or outline form. As one progresses through the text, each idea follows its predecessor in an orderly manner, and thus each chapter forms an easily retainable whole.

Naturally there are some ideas and opinions expressed which could easily give rise to disagreement and lively debate among anesthesiologists, but I do not think there is a single case where an occasional anesthetist would be led into serious or easily avoidable difficulty by accepting the authors' statements as absolute and final truth.

For those who wish to pursue any particular subject further than the scope of this book, the authors have provided handy lists of suggested further reading at the end of each chapter.

All things considered this is a useful handbook for beginners in anesthesia and a handy reference for the occasional anesthetist.

A. V. Gude, M.D.

THE SKIN—A HANDBOOK, Richard L. Sutton, Jr., A.M., M.D., F.R.S. (Edin.) Doubleday & Co., Inc., 1962. Price \$4.95.

The Skin IS AN EXCELLENT MEDICAL HANDBOOK for the layman as well as for nurses, medical students, and general practitioners. Dr. Richard Sutton, Jr. is, as was his father in the past, a well-known author and authority on diseases of the skin. This new series is the answer to the physicians' intellectual and inquisitive patients, who often demand an explanation of their afflictions in simple, lay language. Not every physician is gifted in explaining and clarifying medical problems to the uninitiated layman.

The Skin gives the physician an opportunity to refer his inquiring patient to a textbook written just for him. This layman's textbook gives a clear and comprehensive discussion of the diagnosis, prognosis and treatment of diseases and abnormalities of the skin. Dr. Sutton not only explains the importance of proper hygiene and care of the normal and abnormal skin, but also wisely, in an indirect manner, makes the reader realize that professional knowledge in diagnosis and treatment cannot be substituted by a "do it yourself" kit. Among many other subjects, Dr. Sutton discusses those of present day interest such as injuries from sun, X-rays and nuclear energy. Diseases due to viruses, bacteria and those caused by animals are discussed. An explanation of skin allergies and diseases caused by abnormalities of the psyche are well covered. The clarity and style of writing makes the volume a fine reference book to be desired by any home and family.

William L. Dobes, M.D.

TREATMENT OF INJURIES TO ATHLETES, Donald H. O'Donoghue.

THIS FINE TREATISE on athletic injuries includes an introduction which in itself is worth more than the price of the entire volume if the interested physician would practice the philosophy of treatment of athletes and their injuries as outlined in these first few pages.

Part one, dealing with the prevention of injuries, condenses and makes available much important information not otherwise readily obtainable by the physician.

Part two, on general principles of treatment, embodies many pearls important in the diagnosis and important in the treatment.

Part three, on the treatment of injuries in specific areas, will serve as an excellent reference when these injuries are encountered. The author describes many techniques of examination helpful in diagnosis. Much attention is directed to the methods of post injury rehabilitation. The need of the attending physician guiding and stimulating this phase of treatment is stressed. This treatise on Athletic Injuries is recommended to the novice and the learned physicians enjoying participating in the care of athletes.

Jack C. Hughston, M.D.

ESSENTIALS OF PEDIATRIC PSYCHIATRY, Rubin Meyer, M.D.; Martin Levitt, Ph.D.; Mordecai Falick, M.D.; and Ben O. Rubenstein, Ph.D. Appleton-Century-Crofts, New York, 1962, 203 pp.

WITH THE INCREASED INTEREST in psychiatry as applied to pediatrics, this book is an important addition to the pediatrician's bookshelf.

There is a worthwhile discussion of the changing aspects of pediatric practice and the pediatrician's role in counseling. The book is well grounded in a clear presentation of the principles of normal psychic development. Ample space is given to the problems of infancy which is a topic of special interest to pediatricians.

The familiar development disorders are correlated with the several stages of psychosexual development.

Of special interest is a chapter on "Emotional Reactions to Trauma and Hospitalization." There is a growing interest in minimizing the harmful effects of hospital life on children. Some recent work is presented describing the emotional reactions of different ages. Measures to protect the child's emotional needs are discussed.

There are brief sketches of the more serious disorders of development and finally a chapter on diagnostic measures, prognosis and treatment plans.

A great deal is packed into this volume. The references give access to much recent work. Read with care; this small book becomes a miniature library.

William H. Kiser, M.D.

Green, Morris, M.D., and Richmond, Julius B., M.D. PEDIATRIC DIAGNOSIS, W. B. Saunders Co., Philadelphia, 1962, 541 pp., \$13.00.

THE FIRST EDITION OF THIS BOOK WAS PUBLISHED in 1954 and offered a new and thorough coverage of the diagnosis of childhood ailments. The new edition has been extensively revised and important new additions have been introduced. The book is designed to give help in analysis of particular signs and symptoms. The authors consider the implications of both common and unusual signs and symptoms and trace them back to their causes.

Physicians in search of information to insure that important diagnostic possibilities have not been overlooked will welcome the comprehensive discussions in this book.

Preston D. Ellington, M.D.

Warren H. Cole, M.D.; Gerald O. McDonald, M.S., M.D.; Stuart S. Roberts, M.S., M.D.; Harry W. Southwick, M.D., DISSEMINATION OF CANCER: PREVENTION AND THERAPY, Appleton-Century-Crofts, Inc., 461 pp.

THIS BOOK IS CERTAINLY WRITTEN BY EMINENT investigators in the field of cancer. Warren Cole has spent a life-time doing this and is one of our most famous investigative surgeons. The other doctors, though younger, have well-established reputations. The inevitable course of untreated cancer is a moot question in many physicians' minds. In reading this book, numerous series of untreated carcinomas are followed through to their ultimate conclusion, and are well documented insofar as life expectancy in each individual type of cancer. Each author has kept clearly in mind the dissemination of cancer picture and has also discussed methods of its prevention. Almost all of their information is factual and objective.

The iatrogenic factor in the detachment and beginning spread of carcinoma is for the first time discussed with clarity and in detail. It is understood that this implies the relationship of the physician, who innocently causes the spread of the lesion in his attempt to make an early diagnosis. An effort is made to explain how palpation can best be done and how excisional biopsies with lavage of the open wound with suitable fluid while the cancer cells are out in the open, so to speak, can also be done. An explanation for the seeding out of cancer cells in special localities with the production of secondary tumors is also most interestingly discussed. Specific immunology is considered by Dr. Cole and his associates.

Since this book is written by surgeons, obviously it has a strong emphasis on the most effective means of treating cancer—namely, surgery and radiation; and that we must be gentle to avoid stresses that might promote spread. An alertness to the possibilities of the action of carcinogens and viruses on cells already cancerous is made. The action of chemical substances on the respective cancer cells is also discussed. No predictions are made insofar as chemical breakthrough is concerned, or that cancer will be soon curable.

For all physicians interested in the treatment of cancer, and this certainly constitutes a goodly experience in the practice of any active physician, this book is an absolute must. It is strongly recommended to be incorporated into the library of every physician now in practice. It will also be a splendid volume to instruct the residents and interns who are in the process of completing their training.

Robert H. Vaughan, M.D.

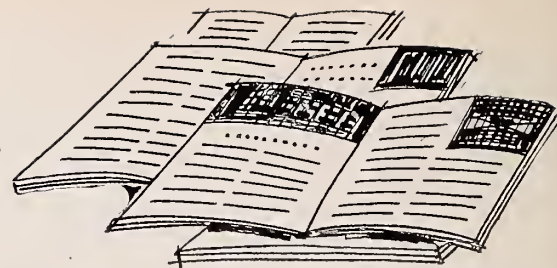
BASIC EYE RESEARCH NOW BEING CONDUCTED AT EMORY

Basic research on the eye now in progress at Emory may help answer the puzzles presented by glaucoma, a disease threatening ten per cent of the population over 40.

Dr. Morton B. Waitzman, recently-appointed director of ophthalmic (eye) research at Emory's medical school, has received three grants totaling \$88,132 for

research in this area. The grants are from the National Institutes of Health of the U. S. Public Health Service.

The new program at Emory is the first integrated basic eye research in this area. Dr. Waitzman has come from Western Reserve University School of Medicine where he directed the Laboratory for Research in Ophthalmology.



Test for Pyelonephritis

IN 13 OR 15 PATIENTS with chronic pyelonephritis, intravenous prednisilone doubled or nearly doubled the urinary excretion of white blood cells.

Katz, Y. J., Velasquez, A. and Bourdo, S. R.: The prednisilone provocative test for pyelonephritis. *Lancet* 1:1144, 1962.

A New Treatment for Haemochromatosis

A NEW DRUG which may have uses in the treatment of haemochromatosis was discussed at the joint annual meeting of the Swiss Societies for Internal Medicine, Cardiology, and Hematology on May 18-20 in Lugano. Workers from Switzerland, Denmark, Germany, and Austria pooled their experiences of desferrioxamine B, a compound formed by several types of actinomycetes. It was first investigated as a possible antibiotic, and its remarkable affinity for iron was observed accidentally. It is one of the so-called sideroamines—natural products which can act as growth-promoters for various microorganisms, and which are known to form iron complexes, but none of which has yet been shown to have such a specific and powerful iron-binding capacity as desferrioxamine B ... in idiopathic haemochromatosis, blood-letting will remain the treatment of choice, though oral and parenteral desferrioxamine B may well find an additional place once the drug is released by the manufacturers (CIBA A.G., Basle). It is unfortunate that in secondary haemochromatosis, usually the result of repeated transfusions in patients with aplastic and other anemias where repeated blood-letting is not possible, the drug is apparently less efficacious than in the idiopathic type.

Annotations—*LANCET* 1:1172, 1962.

Chloroquine Retinopathy

CHLOROQUINE and its hydroxyl derivative Plaque-nil, originally developed as anti-malarial agents, are now widely used in the treatment of arthritis and in various skin conditions. ... Several side effects have been noted. ... Ocular disturbances include the appearance of corneal disoposits, but by far the most serious of these is the rare occurrence of a retinopathy. ... The onset of retinopathy is sudden. The patient may notice a variety of visual disturbances, and though there may be a slight recovery of function if the drug is withdrawn in the

acute stage, very considerable retinal damage occurs and is irreversible. ... The rarity of the complication and the generally accepted value of chloroquine, justify its continued use, in spite of the severity of this side effect.

Arden, G. B., Friedmann A. and Cobb, H.: Anticipation of chloroquine retinopathy—*LANCET* 1:1164, 1962.

Amyloid Polyneuropathy

THE ANCILLARY CLINICAL features of amyloid neuropathy consists of chronic gastrointestinal symptoms, non-specific electrocardiographic changes, dysphonia, and autonomic dysfunction manifested by impotence, orthostatic hypotension, trophic ulcers, and dyshidrosis.

Munsat, T. L. and Poussaint, A. F.: Clinical manifestations and diagnosis of amyloid polyneuropathy. *J. Neurol.* 12:413, 1962.

Hypogammaglobulinemia

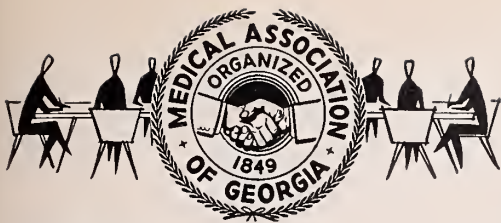
PROMPT, ACCURATE DIAGNOSIS of hypogammaglobulinemia as a cause of unusual susceptibility to infection is essential because serious infection can be prevented by the administration of pooled normal gamma globulin before structural damage has occurred. Gamma globulin should not be administered when susceptibility to infection is caused by other factors. Family history may be suggestive of the congenital type. Since clinical signs are not specific, the physical examination is rarely of diagnostic help and the physician's suspicions must be tested in the laboratory. Standard laboratory tests will identify at least 90 per cent of patients in whom tendency to recurrent infection is due to gamma globulin disturbance.

Janeway, C. A.: *J.A.M.A.* 180:320, 1962.

Cystic Fibrosis and Submaxillary Gland Enlargement

AN ASSOCIATION between cystic fibrosis and chronic enlargement of the submaxillary salivary gland was found in a recent study. In a survey of 106 children with cystic fibrosis and 300 normal children, submaxillary gland enlargement was found in two per cent of the normal children and in 92 per cent of the children with cystic fibrosis. Submaxillary gland enlargement, rarely found in pediatric patients, seems to have diagnostic implication for cystic fibrosis.

Barbero, G. J., and Sibinga, M. S.: *Pediatrics* 29:788, 1962.



THE ASSOCIATION

DEATHS

JAMES CLEMENT WOOLRIDGE, 85, prominent Columbus physician, died at St. Francis Hospital, Columbus, September 7, 1962, after a long illness. In private practice in Columbus from 1910 to 1950, Dr. Woolridge received his medical degree from Columbia University School of Medicine at New York and served internships at Bellevue Hospital, Sloan Maternity Hospital, and Mt. Sinai Hospital, New York.

He was a member of the Muscogee County Medical Society, the Medical Association of Georgia, the American Medical Association, and the Rose Hill Methodist Church of Columbus. In addition to these memberships Dr. Woolridge was a charter member of the Columbus Kiwanis Club, the Shrine, the Masonic Order, and the Knights of Pythias.

Survivors include his wife, Katherine Biggers Woolridge; a nephew, Dr. James M. Woolridge, Midland; two nieces, Mrs. Mary Love O'Neal, Columbus, and Mrs. Roy M. Waller, Sr., Midland; two great nephews, Dr. Roy M. Waller, Jr. and James M. Woolridge, III, and two great nieces, Katherine Elizabeth Woolridge and Sara Eugenia Woolridge, all of Columbus.

HARRY LANGDON CHEVES, SR., of Union Point was drowned on Lake Sinclair near his lakeside cabin at Milledgeville, September 29, 1962. Dr. Cheves was 64. He received his degree in medicine from the Medical College of Georgia and interned in Birmingham, Alabama, where he practiced for 12 years before returning to Union Point where he had practiced for 26 years.

Dr. Cheves was a member of the First Baptist Church of Union Point, the American Medical Association, past president of the Medical Association of Georgia, a fellow of the International College of Surgeons, past president of the Georgia Academy of General Practice, a member of the Oconee Valley Medical Society, and was on the staffs of hospitals in Greensboro, Madison, and Washington, Georgia.

Dr. Cheves is survived by his wife; two sons, Dr. H. L. Cheves, Jr., Union Point and Charles J. Cheves, Atlanta; his mother, Mrs. J. L. Cheves of Virginia; five sisters, Mrs. Bruce Croom, Thomaston, Mrs. John Moorman, Virginia, Mrs. Hugh Garrett, Germany, Mrs. Frank Grunewald, Austria, Miss Ruth Cheves, Syracuse, N.Y.; two brothers, Joe P. Cheves and Johnny Cheves, both of Macon; and four grandchildren.

CHARLES EDWIN IRWIN, 62, died March 29, 1962, in a fire which destroyed his home near Warm Springs, Georgia. He was a graduate of the Emory University School of Medicine and for 20 years was Chief Surgeon and Medical Director of the Georgia Warm Springs Foundation, where he contributed much to the treatment of poliomyelitis. Before his retirement four years ago, he was in private practice in Atlanta.

He was a member of the American Medical Association, American Orthopaedic Association, American Academy of Orthopaedic Surgeons, American Society for Surgery of the Hand, Southern Medical Association, Medical Association of Georgia, and Fulton County Medical Society.

Dr. Irwin is survived by his wife, Mabel; two sons, Charles Edwin, Jr. of Parris Island, S.C., and Michael, of Chattanooga, Tenn.; one daughter, Mrs. Ann Bray, Manchester, Ga., and three grandchildren.

SAMUEL DeWATT WORK, JR., 51-year-old Macon physician, died in a Bethesda, Maryland, hospital, September 10, 1962. An Obstetrician and Gynecologist, Dr. Work had practiced for ten years in Forsyth, Georgia, before moving to Macon, where he had resided for 15 years.

Dr. Work was a member of the Medical Association of Georgia, the American Legion, and the Elks Club.

Survivors include his widow, Edythe of Macon; two daughters, Miss Sandra Work, Macon, and Mrs. Carole Kinchshoe, Anchorage, Alaska, and one grandson.

SOCIETIES

COWETA COUNTY MEDICAL SOCIETY continues to carry out its worthwhile project of shipping drugs to Korea. The drugs are donated by pharmaceutical manufacturers and shipped from Newnan to a small hospital in Korea which has been the project of the society for two years.

EIGHTH DISTRICT MEDICAL SOCIETY held a medical symposium on office diagnosis and management August 17-19 at St. Simons Island.

GEORGIA MEDICAL SOCIETY met October 9 at Savannah and had as its guest speaker Dr. Harry B. O'Rear, President of the Medical College of Georgia.

HALL COUNTY MEDICAL SOCIETY presented a program on community health service as it relates to the school at the September 18 meeting held in Gainesville.

MUSCOGEE COUNTY MEDICAL SOCIETY was the guest of the Martin Army Hospital, Columbus, at a social hour and lecture at Custer Terrace Officers Club September 10. Speaker was Dr. K. T. MacMillan, who spoke on "The Use of Radioisotopes in Clinical Medicine."

NINTH DISTRICT MEDICAL SOCIETY met September 19 at Toccoa as the guest of STEPHENS COUNTY MEDICAL SOCIETY. The program included Dr. Mark Brown, Augusta, who served as moderator for a panel discussion which included Dr. George W. Smith, Augusta, speaking on "Management and Control of Cerebral Vascular Disease;" Dr. Victor Moore, Augusta, who spoke on "Malabsorption Syndrome;" and Dr. Frederick P. Zuspan, Augusta, whose topic was "Hypofibrinogenemia." In addition to

moderating, Dr. Brown spoke on "The Current Status of Lymphangiography."

SEVENTH DISTRICT MEDICAL SOCIETY was the guest of CHATTOOGA COUNTY MEDICAL SOCIETY September 19 in Summerville. The program opened with a welcoming address by Dr. Hugh Goodwin of Summerville, President of the Chattooga County Medical Society. Following the address, scientific papers were presented by Dr. George Young, Chattanooga, Tennessee, on "Pancreatitis," followed by a discussion by Dr. Lester Martins, Rome. Dr. Lamar B. Peacock, Atlanta, gave a demonstration of various means of skin testing to supplement his talk on "Atopic Allergic Disease." An open discussion from the floor followed the talk given by Dr. James I. Achord, Atlanta, on the "Peptic Ulcer." The program closed with a talk given by Dr. C. R. Wilcox, Jr. of Rome, entitled, "Megaloblastic Anemia of Pregnancy."

SOUTH GEORGIA MEDICAL SOCIETY met September 10 in Savannah to hear neurosurgeon Dr. George Smith of the Medical College of Georgia at Augusta speak on "Cerebral-Vascular Diseases."

PERSONALS

First District

At a recent meeting in New York, D. B. FILLINGIM, Savannah, was elected a fellow in the International College of Surgeons.

ALBERT J. KELLEY has announced that CARSON B. BURGSTEINER has become his associate in the practice of Obstetrics and Gynecology in Savannah.

Second District

Chairman of the committee on arrangements for the first medical Seminar at Archbold Memorial Hospital, Thomasville, was H. L. CHENEY of Thomasville.

Third District

W. McCALL CALHOUN, Marion County, in September underwent surgery at the New England Baptist Hospital, a subsidiary of Lahey Clinic in Boston. Dr. Calhoun is reported to be recuperating satisfactorily.

Speaking on Thalidomide to the Americus Civitan Club at their meeting September 18 was HARVEY SIMPSON, JR., Americus. Dr. Simpson also attended the September 20-22 meeting of the Georgia Chapter of the American College of Surgeons held at Sea Island.

Director of the State Department of Health, JOHN A. VENABLE, of Atlanta, spoke September 18 to the Perry Kiwanis Club. Dr. Venable's talk concerned the eradication and reduction of some diseases by modern medicine.

Columbus surgeon, A. S. CONGER, presented a paper September 21 before the Georgia Surgical Society, which held its meeting at Sea Island September 20-22. The topic of Dr. Conger's paper was, "Por-

phyria—Surgical Aspects—With Presentation of Cases."

JACK C. HUGHSTON, Columbus, attended the third annual Seminar on the Medical Aspects of Athletics held in September in Chapel Hill, North Carolina.

Fourth District

H. A. FOSTER of Griffin spoke to the Woman's Auxiliary of the Spalding County Medical Society September 27 at Griffin. Dr. Foster, who is the president of the Spalding County Medical Society, spoke to the members concerning the importance of the physician's wife to her husband's work.

Discussing a paper written by HERBERT KAUFMAN of Gainesville, Florida, at the section on Ophthalmology and Otolaryngology of the Southern Medical Association meeting in Florida in November, was BEN JENKINS, Newnan.

Fifth District

A. H. LETTON of Atlanta, a member of the board of directors of the American Cancer Society, Georgia Division, spoke September 28 to the Bibb County unit of the American Cancer Society.

Speaking at a forum on stroke rehabilitation held October 2 at the Academy of Medicine were JOSEPH C. MASSEE, LINTON H. BISHOP, JR., and HAYWOOD HILL. The October 2 session, fourth in the series was entitled, "Stroke — the Road Back."

"You and Your Heart Attack," was the subject of a talk given by BRUCE LOGUE, Atlanta, at a recent Marion County PTA meeting in Buena Vista, Georgia.

C. STEDMAN GLISSON, JR., ARTHUR A. SMITH, and C. WALTER COOLIDGE have announced the opening of their new offices in the Peachtree Medical Building, Atlanta, for the practice of Gynecology and Obstetrics.

FRED VIDAL, Atlanta, spoke at the dedication and opening of the new eye bank at the University of Florida School of Medicine September 22 and 23.

Speaking at the third in a series of forums on stroke rehabilitation held September 25 at the Academy of Medicine were J. MORRIS PERKINS, T. STERLING CLAIBORNE, and FRANCIS W. FITZHUGH, all of Atlanta.

J. WILLIS HURST, Atlanta, has recently returned from a trip with United States Vice President, Lyndon B. Johnson, to Italy, Greece, Lebanon, Turkey, Pakistan, Iran, and Cyprus. Dr. Hurst went, at the Vice President's request, as his personal physician.

JAMES F. LANGFORD has announced the association of OMER L. EUBANKS at the Langford Clinic in Roswell.

One of the speakers on the program at the October 4-6 meeting of the American College of Obstetricians and Gynecologists held in Charlotte, N.C., was EDWARD BROWN, Atlanta. Dr. Brown's topic was "Pheochromocytoma in Pregnancy."

Sixth District

WILLIAM A. HOPKINS, Atlanta surgeon, spoke to the Bibb County Heart Council in Macon September 27.

I. H. MacKINNON announced September 20 that ROBERT R. HOLT, Professor of Psychology and

Director of the Research Center at New York University has accepted an invitation to act as Consultant to the Department of Psychology at Milledgeville State Hospital. Dr. Holt received his M.A. and Ph.D. degrees from Harvard University, and is a native of Jacksonville, Florida.

Seventh District

No news submitted.

Eighth District

RICHARD B. MOORE, JR., has begun the practice of Urology in Brunswick in association with W. W. PAYNE.

Waycross physician, DUNCAN FARRIS, now has as his associate EDWARD B. BROWN, a Scranton, Pennsylvania, native who served his residency at Grady Hospital, Atlanta.

Ninth District

FRED BLOODWORTH, Gainesville, September 14, became the new president of the Georgia Tuberculosis Association at the association's 49th Annual meeting at Macon.

EXECUTIVE COMMITTEE OF COUNCIL

THE EXECUTIVE COMMITTEE of Council meeting was called to order at 1:45 P.M., on October 11, 1962, by the President Thomas W. Goodwin, at the MAG Headquarters Building, Atlanta.

The members attending were: Thomas W. Goodwin, Augusta; George H. Alexander, Forsyth; George R. Dillinger, Thomasville; John T. Mauldin, Atlanta; J. G. McDaniel, Atlanta; Fred H. Simonton, Chickamauga; John S. Atwater, Atlanta; and Lee H. Battle, Rome. Also present were Vernon Skiles, Atlanta; William A. Wood, Jr., Atlanta; Eustace A. Allen, Atlanta; and Mr. James Baker, Medicare Administrator. MAG staff members present were Mr. Milton D. Krueger, Mr. James M. Moffett and Mrs. Catherine Wooten.

Reading of Minutes

The minutes of the Executive Committee and Council meeting of September 8-9, 1962, were read by Mr. Krueger. There being no corrections the minutes were approved as read.

Special Called Session of MAG House of Delegates

President Goodwin asked Dr. Simonton to repeat his statement at the September Council meeting regarding the possibility of holding a special called session of the MAG House of Delegates. Dr. Simonton stated that he would like to withdraw his suggestion at this time. On motion duly made and seconded it was voted to approve the withdrawal of Dr. Simonton's suggestion for a special called session of the MAG House of Delegates.

1962 Physician's Award from President's Committee on Employment of the Handicapped

The information about the 1962 Physician's Award was given Executive Committee, and was received for information only.

MAG Board and Sub-Committee Appointments

Mr. Krueger read the suggested list of Board and Sub-Committee appointments due to resignations:

- (1) Interprofessional Council: J. Frank Harris, Atlanta; with an alternate, Stephen T. Barnett, Jr., Atlanta.
- (2) Georgia Adoption Practices Committee: William W. Coppedge, East Point.
- (3) Legislative Board: Thomas Gilmore, Sandersville (1963); William Harbin, Rome (1965); with an alternate, Lee Battle, Rome.
- (4) Weekly Health Column Sub-Committee: James Funk, Atlanta; Charles Dowman, Atlanta; Robert C. Shuman, Marietta; and Harrison L. Rogers, Atlanta.

Toccoa doctors attending the Georgia Heart Association Meeting at Jekyll Island September 7-8 were J. C. DUDLEY and SAMUEL H. HAY.

Tenth District

Pathologist FRANK MULLINS, JR. of Augusta has been elected to the active medical staff of Taylor Memorial Hospital at Hawkinsville. Dr. Mullins will commute between Augusta and Hawkinsville in his private plane.

DANIEL B. SULLIVAN, Augusta surgeon, formerly located at 842 Greene Street has moved his offices to the Medical Arts Building, 1467 Harper Street.

Opening new offices September 4 in Lavonia for general practice in medicine is J. N. SHEAROUSE.

Two members of the Medical College of Georgia at Augusta were speakers at the recent meeting of the American College of Obstetricians and Gynecologists held October 4-6 in Charlotte, N.C. JOEL CONNER spoke on "Transvaginal Anesthesia for Labor and Delivery," and JAMES SEGARS' topic was "Ovarian Agenesis."

- (5) Medical Defense Committee: The appointment of a chairman is to be decided after the next Medical Defense meeting.

On motion duly made and seconded it was voted to recommend Council approval of the appointment of the above to the respective Boards and Sub-Committees.

MAG County Society Membership

Mr. Krueger stated that he had received two requests for change of membership in county medical societies, one from Coweta County Medical Society and the other from Ware County Medical Society. On motion duly made and seconded it was voted to refer these matters to the District Councilor, under whose jurisdiction the respective county society would fall. These cases, along with two previous ones referred at the September Council meeting, are to be brought before the Council at the December meeting.

Medicare Report

Dr. Vernon Skiles, Chairman, State Medicare Review Board, and Mr. James Baker, Medicare Administrator, were asked to make a report on the State Medicare Review Board meeting held September 30, 1962. Dr. Skiles reviewed the actions taken by the Board, with the suggested changes in the rules and regulations, subject to the approval of the Executive Committee of Council. The items on which Executive Committee took action are as follows:

- (1) On motion (Dillinger-Simonton) it was voted that the State Medicare Review Board Chairman should continue to check the Medicare claims, and if there are any discrepancies in the claims, to refer them to the Executive Committee of Council. This procedure is to be followed because the Executive Committee is financially responsible for the Medicare Program in Georgia.
- (2) At the State Medicare Review Board meeting it was suggested that the new rules and regulations be published in the *JMAG*. On motion duly made and seconded it was voted to publish these rules and regulations, as amended.
- (3) After discussion regarding the appointment of an Appeal Board, which had been suggested by the State Medicare Review Board, on motion duly made and seconded, it was voted that the Executive Committee should be the Appeal Board, and that the suggestion made by the Medicare Review Board for the appointment of an Appeal Board be abolished.

- (4) On motion duly made and seconded it was voted that the State Medicare Board should be composed of members of Review Boards at all levels.

On motion duly made and seconded it was voted to approve this report with the amendments made in the new rules and regulations as stated above.

Podiatry Association Membership on Interprofessional Council

Dr. William A. Wood, an MAG representative on the Interprofessional Council, stated that at the recent meeting of the Interprofessional Council the Chairman of the Council had stated that the Podiatry Association desired membership on the Council. On motion (Alexander-McDaniel) it was voted to approve the recommendation of the Interprofessional Council to accept the Podiatry Association as a member of this Council.

Proposed AMA Resolution

Dr. Eustace Allen, MAG AMA Delegate, read a resolution suggested by Dr. DeTar to be introduced at the Clinical Session of the AMA in November 1962, regarding Health Care of the Aged. After discussion, on motion duly made and seconded it was voted that no action be taken on the submission of such a resolution.

Family Responsibility Bill

President Goodwin spoke on the Family Responsibility Bill and read a letter received from Dr. John Venable with a draft of the "Patient Pay Proposal" enclosed. This proposal and the Recodification of the Public Health Laws is to be submitted to

the Georgia Legislature. Dr. Goodwin also read the MAG Attorney's reply to the MAG request for his opinion on this proposed Family Responsibility Bill. There was lengthy discussion on this subject. On motion (Mauldin-Alexander) it was voted that a letter should be written to the State Department of Public Health and the State Board of Health, based on the MAG Attorney's letter: (1) That MAG is opposed to the State of Georgia practicing medicine; (2) That Section 1(d) be amended to add the wording in the Attorney's letter as follows: "... Provided that 'cost of care' shall not include charges for the professional services of medical doctors licensed to practice medicine and surgery pursuant to Georgia Code Chapter 84-9."; and (3) That MAG is willing to accept any compromise as long as it is commensurate with the principles of medical ethics.

Treasurer's Report

Dr. Atwater gave the Treasurer's report. He called attention to the Dues and Subscriptions item which is a deficit. On motion duly made and seconded it was voted to authorize the Treasurer to take funds from the Contingent Fund to make up this deficit. On further motion it was voted to approve the Treasurer's report as presented.

Headquarter's Office Report

Mr. Krueger made a report on the headquarters office activities.

New Business

(1) Self-employed Pension Law: It was suggested that the MAG Attorney write an article on the interpretation of this law for publication in the *JMAG*. (2) Date and Site of November Executive Committee meeting: November 4, 1962, 10:00 A.M., MAG Headquarters.

There being no further business the meeting was adjourned at 4:40 P.M.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Brice, Boyce S.	The Harbin Clinic Rome, Ga.	Active	Floyd
Buckner, Michael S.	Phoebe Puntney Mem. Hosp. Albany, Ga.	Active	Dougherty
Cohen, Marshall	478 Peachtree St., N.E. Atlanta 8, Ga.	Active	Fulton
Duggan, C. A., Jr.	2605 Cherokee Avenue Macon, Georgia	Active	Bibb
Eakins, J. Kenneth	Thomasville, Georgia	Active	Thomas-Brooks
Finney, C. E.	716 Monroe, North Albany, Ga.	Active	Dougherty
Flanders, Charles D., Jr.	1308 Church Street Marietta, Ga.	Active	Cobb
Gee, W. N., Jr.	302 Emory Street Valdosta, Georgia	Active	South Georgia
Hartrampf, Carl R., Jr.	1938 Peachtree Rd., N.W. Atlanta 9, Ga.	Active	Fulton
Hatcher, Charles R.	Emory Clinic Atlanta 22, Ga.	Active	Fulton
Hendley, John Ell	208 West Ogeechee St. Sylvania, Ga.	Active	Screven
Howse, Ralph M.	Harbin Clinic, 104 E. Third Street, Rome, Ga.	Active	Floyd
Jackson, Thomas W.	The Harbin Clinic Rome, Ga.	Active	Floyd

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA (Continued)

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Josefiak, Eugene J.	Macon Hospital Macon, Ga.	Active	Bibb
Kent, William R.	208 West Ogeechee St. Sylvania, Ga.	Active	Screven
Leigh, Richard W.	16 Professional Court Rome, Ga.	Active	Floyd
Martinez, A. B.	Milledgeville State Hosp. Milledgeville, Ga.	Active	Baldwin
Matthews, W. Stanley	c/o Base Hospital 804th Medical Group, Hunter AFB, Savannah, Ga.	DE 4	Fulton
May, Robert W., Jr.	136 W. Main Street Cartersville, Ga.	Active	Bartow
McRae, Luther C., Jr.	Box 378 Glenwood, Ga.	Active	Southeast Georgia
Morris, Archie J.	Montezuma, Georgia	Active	Sumter
Nelson, John W.	Pavo, Georgia	Active	Thomas-Brooks
Newton, W. M., Jr.	Medical Center Thomasville Highway Moultrie, Ga.	Active	Colquitt
Nichols, Joseph J.	20 First Street, S.W. Moultrie, Ga.	Active	Colquitt
Parsons, Richard C.	559 Medlock Road Decatur, Ga.	Active	DeKalb
Pearce, T. Elder, Jr.	Georgia Baptist Hospital 300 Boulevard, N.E. Atlanta 12, Ga.	Active	Fulton
Rowell, Roger R.	542 Church Street Decatur, Ga.	Active	DeKalb
Sessions, George P.	2701 North Decatur Road Decatur, Ga.	Active	DeKalb
Smith, James H.	7 Professional Court Rome, Ga.	Active	Floyd
Sotus, Peter C.	1968 Peachtree Rd., N.W. Atlanta 9, Ga.	DE 2	Fulton
Stone, H. Harlan	69 Butler Street, S.E. Atlanta 3, Ga.	Active	Fulton
Tarnasky, Ralph E.	Macon Hospital Macon, Ga.	Active	Bibb
Thomas, R. P.	Medical College of Georgia Augusta, Ga.	Active	Richmond
Uehling, Edward R.	2910 N. Druid Hills, N.E. Atlanta 6, Ga.	Active	DeKalb
Ward, Daniel F.	Louisville Street Harlem, Ga.	Active	McDuffie
White, Charles R.	763 Pine Street Macon, Ga.	Active	Bibb
White, William H., Jr.	517 Park Street Gainesville, Ga.	Active	Hall
Wilcox, C. R.	10 Hospital Circle Rome, Ga.	Active	Floyd
Wilson, William J.	Elberton, Ga.	Active	Franklin- Hart-Elbert
Woodard, Otis J., Jr.	234½ Pine Avenue Albany, Ga.	Active	Dougherty

District Society Officers

First District

R. B. Gottschalk, Savannah, *President*
V. J. Cirincione, Savannah, *Secretary*

Second District

James H. Crowdis, Blakely, *President*
Julian B. Neel, 207 E. Jackson Street,
Thomasville, *Secretary*

Third District

Robert H. Vaughan, Medical Arts Building,
Columbus, *President*
Robert Collins, 142 S. Jackson Street,
Americus, *Secretary*

Fourth District

Norman Gardner, Thomaston, *President*
Morgan Kellum, Thomaston, *Secretary*

Fifth District

Leslie Buchanan, 374 W. Ponce de Leon
Avenue, Decatur, *President*
Carl C. Jones, 1293 Peachtree Street, N.E.,
Atlanta 9, *Secretary*

Sixth District

J. P. Woodhall, 724 Hemlock Street, Macon,
President
Hugh K. Sealy, 765 Spring Street, Macon,
Secretary

Seventh District

Remer Y. Clark, 1422 Cherokee Street,
Marietta, *President*

Eighth District

Duncan Farris, 202½ Folks Street, Waycross,
President
Neal F. Yeomans, Waycross, *Secretary*

Ninth District

Rupert Bramblett, Cumming, *President*
Hamil Murray, Gainesville, *Secretary*

Tenth District

James A. Green, 1010 Prince Avenue, Athens,
President
C. E. Wills, Jr., Washington, *Secretary*

Specialty Society Officers

Georgia Heart Association

A. Calhoun Witham, Medical College of
Georgia, Augusta, *President*
J. Willis Hurst, Emory University Hospital,
Atlanta 22, *Secretary*
Mr. Linwood Beck, 58 Balto Place, N.W.,
Atlanta 9, *Executive Secretary*

Georgia Pediatrics Society

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Cover

The weather worn posters on our cover serve to remind all that Georgia has just finished a most active political contest in which medicine had a big stake. As this cover suggests, politics is always "just around the corner."

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THE GENERAL PRACTITIONER AND THE THIRD DIMENSION

T. A. Watters, M.D., *Metairie, Louisiana*

■ *A physician renders a service, to be sure,
but he also dispenses understanding.*

LIFE TODAY IMPOSES STRESSES which compound problems for both the physician and his patients. People become ill in a web of personal turmoil, sicken from quandary, and despair from hopes deferred. Nonetheless, with the help of heartening recollections from more tranquil times, human care, and medical aid, they recover. Yet these emotional elements, so frequently in the onset and outcome of illness, are vexing to many doctors, and test their ability to do *full doctoring*. It is this broad and subtle area of medical opportunity that has interested those in the New Orleans Study Program for Non-Psychiatric Physicians who are rounding out their skills in order to treat the *whole person*.

Organic Bias

Unfortunately, an *organic bias* often overlies a physician's emotions, while at the same time fostering oversight, exclusion, or at least a minimizing of functional factors. Misconceived scientific objectivity may also keep him at a chill psychologic distance from his patient and protect him from becoming emotionally involved. Yet it is possible for an astute clinician to be subjective and sympathetic, while at the same time maintaining a flexible position of concern. He cannot only identify with his patient, deriving therefrom intuitive observations, but also counter any tendencies that exceed prudent bounds of medical assistance. Those physicians who might haughtily question the warm, human approach on scientific

grounds, cannot dispute the fact that tendering and understanding skills are of untold value, and are sorely needed today. It is paradoxical that a rigid conception of detached doctoring, cold as it frequently is, exists in a society characterized by mutual dependence.

A physician renders a service, to be sure, but he dispenses a commodity as well, namely understanding, which when properly offered is salutary, brings hope, mobilizes determination, and promotes healing. Although a doctor's halo of status and popular acclaim can affect positively the more impressionable patient, in the long run something will be lacking in his *therapeutic function* and unenduring in its results, if he is motivated by research and prestige alone. In healing relationships there are some human essentials that become evident, such as acceptance, understanding, and care, and if they can more abundantly be included in our doctor-patient relationships in general, a more favorable image of the doctor in the public's mind will be restored. Through skillful care, doctors can relate to their patients as friendly helpers. Is there any better way to further public relations?

Scope of Observation

Those in the New Orleans Program seek to extend their scope of observation, and bring out any adverse attitudes and attributes that impair their relationships, in order to modify them. Motivation and counter-motivation for doctoring are carefully considered,

because in this area a turn is frequently made toward the use of two of his best medical tools, such as his personality, and an attitude of curiosity blended with compassion.

Also under scrutiny is physical fitness based on a sensible program of rest and relaxation with time on and time off, something appreciated by the doctor's wife, who is a vital member of the medical team. As a source of encouragement or disharmony we have come to respect the wife's position and role in medical functioning as one whose influence for good or ill is not to be underestimated. Overwork on the part of the physician resulting from living out the role of an all-perfect mother, fosters dependency in his patients. This soon shows up in his case presentation, not arriving at group meetings on time, imperfect attendance, and evidence of pernicious building up of tension.

An Opportunity

We deliberately set up an opportunity for each participant to recognize any vicious circles such as an overload of patients, frustration, suppressed hostility, tensions, depletion, stimulants, more activity with deleterious changes accruing within. This example of a driven person, rather than one living judiciously, is a pattern of behavior often looked upon as dedicated. Such a life, when studied, constitutes a riddle with numerous implications. So, one can debate whether this doctor is advancing himself through such overzealous devotion, his profession through feverish application, or his patients, whom he allows to cling to him so demanding. Are they helping him or pulling him under? The tragedy is that if the doctor cannot find a way out, depression with a core of desperation closes down upon him.

A knowledge of unconscious operations and how they influence illness, recovery, and the dynamics of care, is a factual necessity. Symbolism, hypnotic phenomena, and psychosomatic medicine affirm their existence, the force and portent of which the priests of Aesculapius earlier noted. But full appreciation of their subtle effects within man unfortunately requires convincing, personal experience. In one of our groups, a member will in time have the opportunity for some sort of experience of this nature. It was this type of learning about oneself to which Greek temple physicians referred when they cut into their structures, admonishing, "Physician, heal thyself." Although more modern physicians are aware of these operations, still all too prevalent is a form of medical thinking devoid of this important *third dimension*, where frequently lies the *modus operandi*. One might speak of this as *negative thinking* because the rational process negates the presence of human facts.

Our group method pools the abilities and experiences of participants into a process which studies disorder and its development in the clinic of life. With case presentations and representations taken from real practice, factual material soon speaks for itself. Emotional data, such as interpersonal or intrapersonal feelings that bear upon the disorder, do not long remain hidden from this collective search and evaluation, and when brought out are given thorough consideration. Because speculative thinking so easily finds its way into the process when interpretive sallies are made, our leaders adhere to what is evident and confirmatory.

We choose not to encourage use of the term "psychiatric" patients because this adjective can be both false and misleading, in that it singles out the more disturbed person and perpetuates a biased overemphasis on one segment of patients, rather than the larger and less threatening number in everyday practice. Our participants select cases for presentation that are problems to them. The group does all it can to help the individual member scrutinize and clarify his case, but it never tells him what to do or how to do it. Ingenuity is encouraged, along with enlightenment.

A medical situation sometimes enters a static phase and therapeutic effectiveness comes to an impasse. Sometimes an exchange of roles is encountered wherein the doctor takes the part of the complaintive recipient of help. This may occur especially during stressful times in his own life, and a patient becomes the listening, reassuring one. A patient may retain symptoms in order to take care of the doctor unobtrusively, because one day she may need him for an acute episode of her own.

Importance of Personality

The importance of the personality in therapy is sharpened when acceptance, with its reviving effects, and support, with its strengthening effects, are observed. The delight of belonging, contrasted with the demoralizing drop of rejection also is seen. Through group dynamics a participant feels these things personally, making the significance of these emotional forces more convincing. In an atmosphere less dogmatic, less critical, and less threatening, *unlearning* as well as the learning of third dimensional operations is permitted. A change is noted when a group member relates to patients in a less authoritative manner, and consequently does not have to give as many orders, suggestions, and answers, but rather works with more ease, imagination and freedom from automatic responses. Over-precaution, defensiveness, and aversion to certain cases formerly present subside, and his doctoring extends its scope as well as

depth. As he becomes less anxious and emotional, understanding, intellectual honesty and natural sincerity evolve, and therapeutic results become more evident. He feels better because he is "doing something for the patient." This reduces frustration and guilt in himself.

Under group auspices, venture and risk are tinged with sensible discrimination rather than innovation. Work with the human element is not only sanctioned, but deemed medically respectable, so its member is neither embarrassed nor wounded by jibes from his colleagues. In a climate of acceptance he develops more serenity and self confidence, and is reoriented toward his professional heritage. He gains a new realization of what it implies, and his responsibility toward the whole person. A valid status value derived from fully helping his fellow man, and seeing relief accrue therefrom, puts to rest any doubt about the importance of being a practitioner of medicine. With more appreciation for emotional forces and their effects when blocked; for distortions in human communication with lessened chance for success in life; for the agony of disappointment when it comes—he observes how all these things not only impede human relationships, but undermine health as well. Conversely, he also recognizes the inherent possibilities for amelioration and change in the doctor-patient relationship.

The Patient Decides

Too, the participant learns that the patient is the one who decides if psychotherapy is used—the doctor only determining *how* it is applied with awareness and safety. Further, he learns that patients presume he has a tailor-made knowledge about them—that he will take away their anxieties and give special favor and protection. And, above all—he will not reject them!

Governed by feasibility, the doctor must carefully weigh opportunities, goals, and ideals. He will be mindful always of his patient's socio-cultural background; human setting, intellectual grasp, inherent capacity, intent, and perseverance, and his emotional acceptance of a plan for corrective effort, self-understanding and change.

A clinician does well to ascertain any pre-formed attitudes, and predetermined suggestibilities originating from what has been heard or thought up about the doctor himself. Ideas prevail about doctors as people and as doctors, and about what the healing role is. These stereotypes are precipitated out by centuries of usage, and are projected upon physicians of the present, including those chosen by the patient. The difference between the stereotype and the actual physician may be not only disturbing, but sustain symptoms as well. Further, patients may set limits on therapy if the future is more complicated without the disorder. If their circumstances are unavoidable and

their environment unalterable, then a choice may be made in favor of enduring discomfort.

Even when ill, persons want to be regarded as having dignity and significance and be accredited with self-sufficiency. Usually not consulted when all is well, but rather when there is trouble and strain, the patient presumes that the physician will decipher the turmoil and eliminate the torment. Strangely, this attitude is derived from the theory of actual possession of devils. An added task is the disclosure that the patient also has a responsibility toward his own recovery and is not to be treated as a child, either because he favors this role, or because some physicians carelessly cultivate such habits in handling people—which is quite disturbing to some patients.

Good Listener

Naturally, the physician is expected to be a good listener, because some people come to him purely to be heard, and his informed listening can in itself be curative. Such is a super-skill, because it integrates hearing with perception, intuition, and inference. When appropriately used, listening establishes a relationship wherein a person accepts the listener because he understands him better than he does himself. Listening not only builds trust, but it helps clarify problems, pointing up those which have priority over others and actuates efforts toward their solution.

However, listening may not in itself be enough for some patients. An individual whose tie with reality is weak, and who fears losing his identity, may need support. But some people are sensitive to its use. As with hospitality, one must exercise some selection before extending it. Otherwise the response may be negative and the generous gesture spurned. This is because help-giving and sharing vary in their emotional meanings to people. Pride may be threatened when aid is furnished, and outright hostility may be mobilized. In other instances where patients become aware of the strength of their help-seeking needs, hostility is mobilized, but inverted, with a resulting depression.

Reassurance is a light, tactful type of support that may or may not be acceptable. It is most helpful where there is reasonable opportunity for solution of problems and hope of relief from conflictual struggle.

Resentment Requires Hearing

Smouldering resentment, whatever the cause, requires full hearing, and anything in the nature of slight or neglect on the part of the doctor may result in its intensification. Quite a few patients are triggered to expect maltreatment and are distrustful—the reason being that previous doctors may have given them too little consideration earlier in life, even as far back as childhood. Another possible cause is

that parents sometimes indoctrinate their children with the idea that doctors hurt and chastise, making the doctor a positive agent for harm. All too often a child, although a central figure in medical maneuvers, is given little if any explanation for what is done to him. As a result, when his mental development is well along and on into adulthood, this person nurses feelings against doctors, thwarts them in their efforts, and will not respond to their ministrations. He is often unaware of the underlying causative experience, but feels unfriendly toward them. These people eagerly respond to nonmedical therapists, and any physician becoming involved with such patients learns bitterly this fact. It illustrates how one can eat the sour fruit from a predecessor's planting.

Interpretation

With so much intensive psychotherapy in use, one frequently hears mention of interpretation. A physician might be tempted to use it if the better part of clinical judgment does not counsel him to leave it alone. However, if he does choose to try it, he discovers that interpretative work can mobilize primitive responses towards him which may intensify as well as complicate the relationship. If he is not adept in handling what has been stirred up, and in seeing the person through this phase, it may be painful to both parties. In the end he is left with the regret that he did not leave interpretation to the psychiatrist.

Concept More Usable

In the past, insight as an awareness of being ill or not being ill was frequently employed in differential diagnosis. Today, considered in terms of *self*-understanding, response to reality, and potentials for psychologic survival, the concept, although broader, is more usable. With discreet questioning, a trusting patient may relate how he perceives something is wrong with him; but may not be ready to correlate insight with pride or blame, and the nature of his distress. Insight has a tendency to move one toward action and commitment of some sort. Hence it should not be prematurely enforced upon anyone, nor set up as a therapeutic end in itself. If such occurs, one might achieve academic ends, but not wholesome therapeutic results. Above all, the clinician should have insight into himself and his relation to the patient. The doctor's insight goes along with psychologic distance—both important in therapy because patients with emotional problems have previously had rejective experiences, and being wary of them, may yearn for a close relationship. So, if one has evolved, and is then broken, a doubt about his value as a person may further damage his self-confidence and make

recovery more difficult. The clinician, therefore, should not fearfully take flight from a relationship because his patient takes on the connotation, "psychiatric patient"—sometimes after he has been with him through thick and thin for years. To leave him at last, is to part, leaving the patient feeling that this is a final rejection.

The Unwitting Clinician

While being helpful, a clinician may unwittingly foster a closeness simulating intimacy, sometimes exciting, but also productive of anxiety, which aggravates the symptoms. Claims of infantile dependency when gratified too much, or too long, or with promises made that imply their fulfillment, yet cannot be carried out, end up as rejective injuries. The relationship is thereby impaired and skepticism consolidated about human relations. Another troublesome situation occurs if the doctor encourages dependency upon him for the simple complaints and irregularities of living. Still another cause of distress is provoked by a physician, hurried by his work load, who rejects the patient non-verbally, while at the same time is accepting of him verbally. Impatience, irritation, and inattention, if perceived as evidence of displeasure, sometimes stimulate unconscious spite, or a derisive caricaturing of the physician as a poor one by an increase in complaints, or an outcropping of fresh symptoms. At times the medical atmosphere can reach a feverish pitch.

Verbal commitments, if not made prudently, may be anticipated with more reality than was intended, and end up in disappointment. What the doctor means to the patient may not be what he himself conceives his role to be. It is wise before making promises to pacify the patient at the moment, to have some conception of what the promise ultimately means to the patient. A thorny path is in prospect if he is too gallant with the lonely-hearted.

Talking too much is a negative skill, and easily becomes a liability. So the doctor must be careful about what he *prescribes by mouth*. Promises, predictions, and invitations made before he knows about his patient, can be grave therapeutic sins, because he has talked too much himself and not let the latter tell the doctor what he came to say about himself. Only by refraining from talking, and listening instead to the story behind the story, does one ascertain operations in the third dimension, where so often the secret key to misery and misfortune is hidden.

The Ideal Clinician

Along with astuteness and humane consideration, the ideal clinician is *humble*, because he knows his profession holds in readiness a vast amount of knowledge, with certain areas studied intensively and prac-

ticed by those who specialize more in those fields, yet who carry on no less full doctoring from their own point of view. One should tap this knowledge through consultation and referral calls for some propriety and protocol, because referrals are often attempted after saying too much too quickly, without considering the patient's fears. This is often the case if the matter is disposed of in one sitting. Most people cannot confront important matters so hurriedly in such a short time, but can digest them in a *fractional* way during several interviews over a longer period. If the doctor has a negative attitude about psychiatry, it is easy for him to be manipulated into a position against referral. At other times, if the doctor is openly hostile, or critical of psychiatry, the patient is not likely to accept referral, because it would offend the doctor. Some patients, aware of a doctor's fear that the referral would be an expose of his professional practices, demur rather than be referred and be thought an informer. Eminently clear as two causes for mis-carried referrals are negative attitudes towards psychiatry, and negative feelings about psychiatrists, carried into their medical relationships by doctors as reflections from problems in themselves. A doctor's uneasy conscience from not having done something earlier for the patient; or his fear of being rejected by the patient's family and losing their community sanction, may cause him to withhold the suggestion of a referral. Fear of rejection on the part of either party singly, or conjointly, in the medical relationship, can easily lead to a by-pass around psychiatry.

Physician Must Know the Psychiatrist

However, where a referral is made willingly, it is best for the physician to know the psychiatrist, both as a person and a physician, when he is referring a patient. Furthermore, it is his responsibility to know whether or not he is competent to deal with that specific patient and his disorder, and whether they would be compatible in the relationship. Many times an *evaluation* by a psychiatrist who can collaborate with the referring physician through a supervised relationship makes it possible for the patient to remain with his personal physician, yet be helped psychotherapeutically. Such an approach can be very instructive to the doctor, and may be the pattern for more teamwork in the future.

In study groups, the same thing can be achieved through the group process to which two psychiatrists contribute. However, if the patient specifically needs a psychiatrist and undergoes treatment by him, a referral discreetly handled will return him to the referring physician without impairing their basic relationship. It will be an even better one, provided the relationship was a satisfactory one to begin with. In fact, it is most desirable that a personal physician

remain willing to fulfill his role, throughout the period of the patient's treatment by the psychiatrist. He may be of immeasurable help at times, and with the right spirit, decisively enter into a favorable outcome.

Sometimes a physician feels he is not fully appreciated, because his patient talks about the psychiatrist's wonderful or objectionable qualities. This is usually the result of overestimation, and should not be taken altogether at face value. Such statements at times reflect a patient's feelings toward his personal physician, idolized without his shortcomings, or exaggerated beyond his worst faults.

Professional Courtesy

A psychiatrist as a physician should extend professional courtesy to his colleagues. Most of all he might remember that the patient was not his to begin with, and as a rule will return to the referring physician if his dignity and maturity were respected by him. A psychiatrist also should communicate with the referring physician upon completion of an evaluation; after therapy gets underway; and from time to time during its course, as circumstances dictate, respecting always the patient's wishes in the matter. At times the psychiatrist hears things a patient will not tell his general physician, and this confidence must be honored without the personal physician taking offense. In therapy, the ultimate is that repair and reconstructive work will enhance the patient's facility for effective relationships, which includes one with his doctor as well.

In pursuit of an effective method for teaching non-psychiatric physicians, ours has been interesting, and quelling of fears arising from preconceived notions about patients with emotional problems. We have found the group a ready medium for the unlearning-learning experience that graduate physicians value. For its optimum function, the group process requires leaders who are clinically experienced, enthusiastic, perceptive, like teaching, and who are respectful of physicians in practice and not connected with academic life. *Practice*, from the standpoint of our programs, is the final *common denominator* of all things medical. In that we do not focus on therapy itself as other groups do, our own groupings call for some screening. We carefully observe and take into consideration all evidence of a participant's wish to do full doctoring. This we further in every way through the use of many techniques of teaching that a group can offer.

Study Attitudes Well

Disquieting as some public attitudes are regarding our profession, we must study them well. For out of this may emerge vital suggestions for our future course. This is no easy task, because painstaking ap-

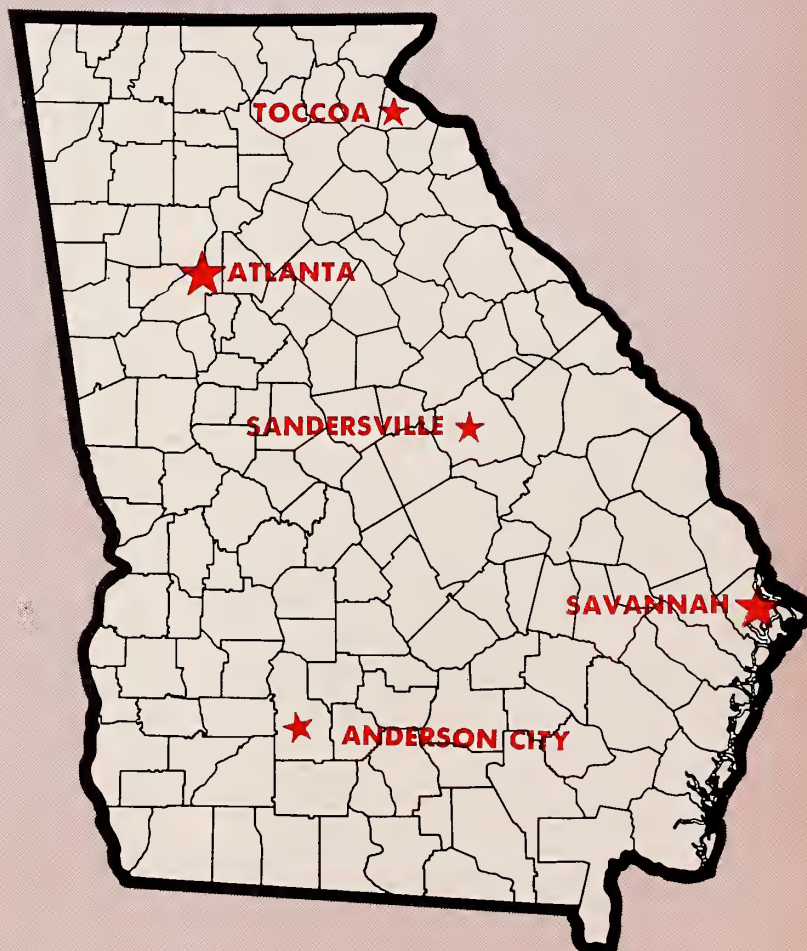
praisal is needed to separate unfair accusations, made by those with political aims, from those conjured up by advocates of a chimerical social order, and from still others made by a sophisticated public which does not forgive us for neglecting the human element in illness and recovery. Out of it all we might rediscover basic aims that cluster around the individual as a person to be helped, rather than focused on the entity of disease itself. With a concerted movement in the direction of science and research, at hierarchal levels of status and prestige, the practitioner finds himself

shifted down the ladder. Seemingly in the shuffle as well, the patient too often is serving science rather than science serving him! However, out of this paradox might emerge a value system that is historically familiar—perhaps something we have deserted during troubled times and befuddled goals. Our groups, in thrashing over their own values, have concluded beyond question that a patient-physician relationship, providing the best of all that medicine can offer, is a fundamental. Further, that the finest of all moments in medicine occurs when a practitioner, oriented to the whole man and moved by a philosophy of total service, is doctoring that man.

429 Iona Street

How well are we telling our story?

To a large degree the ability of the medical profession to be heard in the legislative halls of the nation is directly related to the extent to which the profession's views are shared by the public-at-large. To increase public understanding and acceptance of policy positions enunciated by the profession we must make our position known to the lay public. Regardless of the subject, be it medical, social or political, when physicians address lay audiences, "grass roots" support for the profession is enhanced. Here is a pictorial illustration of how well we are telling our story to the public.



PARADOXIC EMBOLISM

Arthur M. Knight, M.D., *Waycross*

■ *This discussion is based on a case of atrial septal defect in an elderly patient and a case of embolic occlusion of a patent foramen ovale.*

PARADOXIC EMBOLISM is a condition in which emboli derived from the systemic venous system reach the systemic arterial system by passing through an abnormal communication between the chambers of the heart. Such an event is uncommon clinically and occurs only in special circumstances. The writer has recently had two interesting cases which came to autopsy and which shed light upon these special circumstances. The first case was one of atrial septal defect in a woman 71 years old and the second case involved embolic occlusion of a patent foramen ovale.

Case One

E.C.S. was first seen by me when she was 57 years old and followed until her death at age 71. She had been a sickly, frail infant and had had many illnesses in childhood. Her health improved around age 14 years. She fainted many times in adolescence. She bled severely after her first baby. She had two children and one miscarriage. Before age 27 she was quite thin, but she began taking on weight thereafter. During the years that I knew her, she was a very large woman, having a large skeleton and good musculature. She got along remarkably well except when suffering from some type of arrhythmia. She had attacks of atrial tachycardia, atrial flutter and atrial fibrillation. These were infrequent at first, but became more frequent as the years went by. Frank congestive heart failure did not set in until she was 69 years old. She did not have angina pectoris until the last year of life. She had severe exertional dyspnea and nausea for two weeks and swelling of the abdomen for two days before she was found dead in bed. Blood pressure varied from 150/80 to 180/100. Her heart was enlarged when I first saw her, with increased cardiac dullness to the left in the third as well as the fifth left

intercostal spaces. There was a grade iii systolic murmur heard best in the third left intercostal space adjacent to the sternum. Fluoroscopic examination of



Figure 1
Atrial septal defect in Case One.

the chest revealed a large heart with a very large right ventricle and right atrium. The pulmonary artery was also large and vigorously pulsating. A hilar dance was noted. The electrocardiogram showed right bundle branch block.

At autopsy there was no cyanosis. The heart weighed 600 grams. There was marked dilatation of the right atrium and right ventricle. The walls of the right atrium and right ventricle were hypertrophied. The thickness of the right ventricle was only slightly less than that of the left ventricle. In the atrial septum there was a defect measuring some three cm. in diameter (Figures 1 and 2). The pulmonary trunk was dilated, being larger than the aorta. This dilatation extended to the main branches. There was moderate atherosclerosis of the wall of the pulmonary artery.

Case Two

C.W.S. was a 75-year-old male who had a cataract operation and died nine days later. On the third postoperative day he developed sudden chest discomfort accompanied by a spike of temperature and a marked

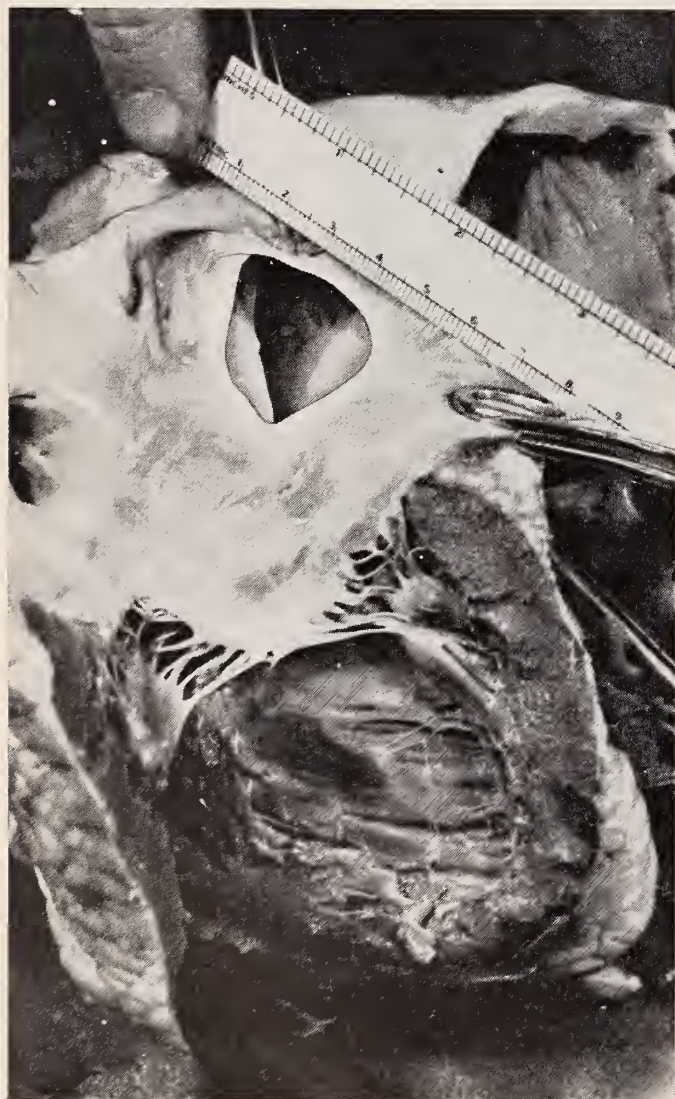


Figure 2
Defect in Case One seen from other atrium.

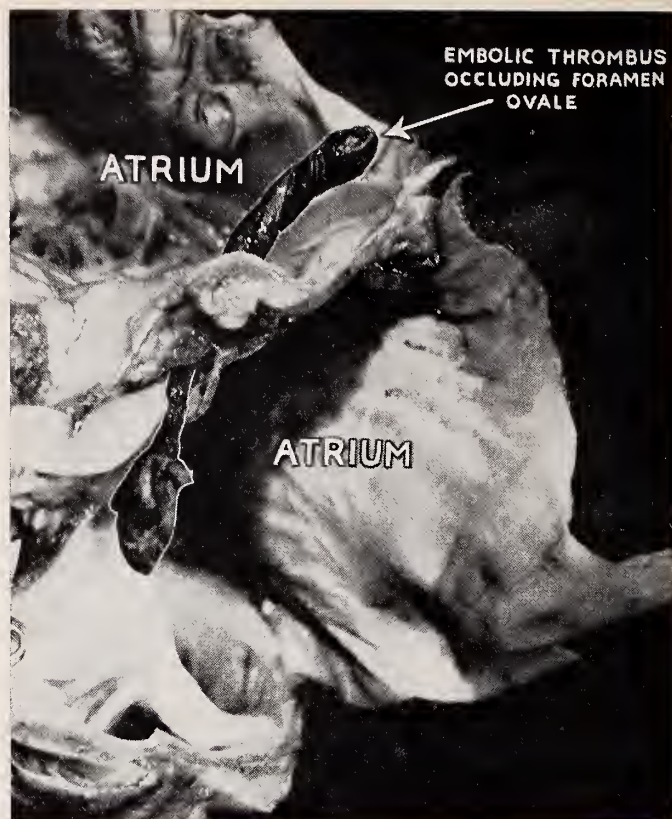


Figure 3
Impacted thrombus in Case Two. The knob-like end is in the left atrium.

drop in blood pressure. This was followed by incomplete recovery. In the recovery phase, there was grayish pallor, moderate cyanosis in spite of oxygen, profuse sweating, marked hypotension, fast thready pulse, and only moderate venous distention. The electrocardiogram did not show changes of acute cor pulmonale. Chest X-ray showed areas of consolidation in both lower lung fields. On the ninth postoperative day, there was sudden deterioration and precipitate death.

At autopsy the significant findings were in the heart, lungs, and veins. The left ventricular wall was quite thick. The right ventricle and right atrium were both acutely dilated. A patent foramen ovale was present and contained an embolus (Figure 3). The embolus was a pencil-shaped thrombus measuring some five to six cm. in length and approximately five mm. in diameter. It extended out into the free cavity of each atrium (Figure 4). Large infarcts were present in the lower lobes of both lungs. Several antimortem clots were located in the main pulmonary artery and in several of the secondary branches to both lungs. Similar clots were noted in the external iliac and femoral veins.

Discussion

Atrial septal defect is the commonest type of congenital cardiopathy in persons over age 50. Cardiovascular surgeons have successfully corrected this defect in several patients over age 60. These patients have remarkably few symptoms until the last few years of life, when they begin to complain of angina

pectoris, palpitation, and symptoms of heart failure. The most outstanding physical finding is the murmur which is systolic in time and located along the left sternal border. Some cases may even have a diastolic murmur or diastolic rumble at the apex. X-ray and fluoroscopy reveal a large heart with dilatation and pulsation of the pulmonary artery and its branches. The left atrium is not enlarged. The pulmonary artery is prominent. The right ventricle and right atrium tend to be enlarged. Electrocardiograms show incomplete or complete right bundle branch block. This is said to be due to diastolic overloading of the right ventricle, dilatation of the outflow tract, and right ventricular strain. It is reversible by surgical closure of the defect. Diagnosis of atrial septal defect in older patients will be missed if this possibility is not kept in mind. Paradoxical emboli have been reported in 27 patients over the age of 60, but the leading cause of death in atrial septal defect at all ages is congestive heart failure.

Etiology

In the usual etiology of paradoxical embolism, a large pulmonary infarct causes a rise in pulmonary resistance sufficient to cause reversal of flow through a patent foramen ovale or other septal defect to a right-to-left direction. A subsequent embolus, usually from a thrombosed leg vein, may then pass through the defect into the arterial circulation. A larger embolus will become impacted in the foramen ovale. In cases of massive pulmonary embolism, a patent foramen ovale helps prolong life by providing a shunt. This is a sort of emergency outflow. When this shunt is blocked, death is precipitated.

The two cases discussed help shed light on paradoxical embolism. Individuals with high pressure in the right side of the heart do not survive to become members of the older age group in which thromboembolism is common. As long as the pressure in the left atrium is greater than that in the right atrium, an embolus from a systemic vein will find its way into the lungs. It is only after a considerable amount of the pulmonary circulation has been obstructed by emboli that the pressure in the right atrium becomes great enough to create a right-to-left shunt which would favor paradoxical embolism. One can see that paradoxical embolism, when it occurs, is of very serious significance and is likely to be prognostic of impending death.

Summary

1. A case of atrial septal defect in a woman aged 71 is briefly discussed.

2. A case of embolic occlusion of a patent foramen ovale in a man aged 75 is briefly discussed.
3. Circumstances under which paradoxical embolism can occur are discussed.
4. The gravity of paradoxical embolism from a prognostic point of view is emphasized.

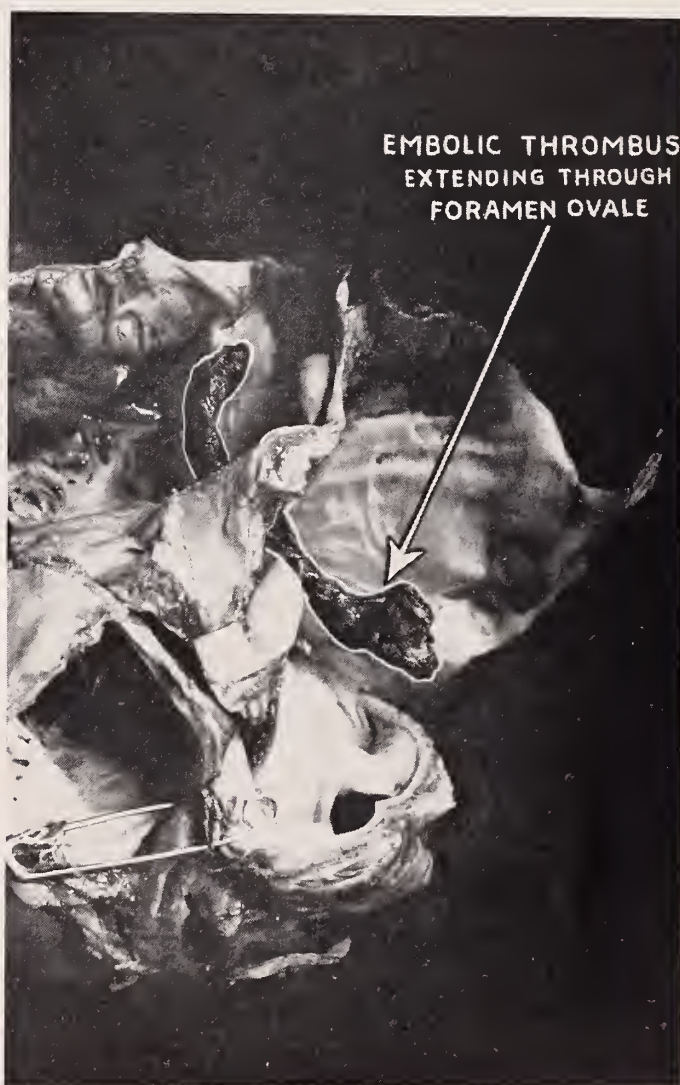


Figure 4

Another view of the embolus occluding the foramen ovale in Case Two.

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THE CASE FOR TEMPORARY GASTROSTOMY IN PEDIATRIC SURGERY

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■ *This life saving procedure is fraught
with few serious complications.*

THE MOST COMMON mode of death in the infant surgical patient is aspiration and the pneumonitis which follows. The Levine or other nasogastric tube is notoriously faulty in its decompressive action. These tubes have less than adequate sized lumens which are necessary in order to be inserted into the tiny nasal passages of the infant. In the postoperative period, a failure to remove the accumulated gastric secretions, saliva and swallowed air can lead to gastric dilatation and distention of the remainder of the intestinal tract with its inadequate peristalsis. Vomiting of typical coffee-ground fluid with a staining of the corner of the mouth is the hallmark of gastric dilatation in infants. The dilatation and vomiting lead to aspiration in the sick infant with a weak cough reflex. There is also a reduction in respiratory exchange from the distention and its pressure on the diaphragms. In addition, there are serious circulatory changes related to compression on the vena cava. This is not to mention the enhancement of wound disruption which distention and vomiting causes. It is for the prevention of these life threatening changes that gastrostomy has its greatest value. A further dividend is the factor of its aid in the initiation of feedings.

Varying Cases

Holder and Gross reported a series of 187 cases of infants with intestinal obstruction varying from esophageal atresia, small intestinal atresias, malrotations, meconium ileus, and imperforate anus, in whom gastrostomies were established. Eighty-three per cent were in infants less than ten weeks old.

There were no fatal complications from the gastrostomies. The only major complication was leakage around the tube in one case, requiring an operative closure of the gastrostomy. The minor complications included one case in which the tube blocked off the pylorus and this was corrected by pulling up the tube



Figure 1

X-ray Case One. Taken at 32 hours. Showing free air beneath diaphragm.

and coapting it to the abdominal wall. There was one granulation tissue overgrowth treated by silver nitrate applications. Their major indications were for decompression purposes and for the initiation of feedings.

Meeker and Snyder used gastrostomy prophylactically in 140 consecutive cases of newborns requiring abdominal surgery, from 1957-1961. They noted a survival in the premature infant surgical cases with gastrostomies of 86 per cent.

Case Report One

T. H., a female baby, was born at Crawford W. Long Hospital, Atlanta, Georgia, on November 7, 1961, weighing five pounds, ten ounces, in a normal, spontaneous delivery. The mother was toxemic but no polyhydramnios was noted. Shortly after delivery the skin was noted to be dusky, and no meconium stools were passed for 32 hours. There was then noticeable distention. X-rays revealed free air under both diaphragms (See Figure 1 taken at 32 hrs.). There was a firm tubular mass palpable in the right lower quadrant of the abdomen. The remainder of the examination was negative. Exploratory laporotomy was done and meconium ileus was noted with firm thickened meconium in the lower 20 cms. of the ileum. There was a perforation of the ileum through which meconium was seen protruding. An ileal resection and removal of the proximal meconium was done and a double-barreled Mikulicz ileostomy was done. A Stamm type gastrostomy was also done. After closure of the ileostomy eight days later, a cecostomy for decompression and irrigation was done and the infant made a good recovery. A small fecal fistula closed spontaneously and the gastrostomy and cecostomy tube were removed. The infant was discharged and has done well since (See Figure 2).

Comment

At one time during the hospitalization, the infant vomited coffee-ground material during the night. The



Figure 2
T.H., Case One. Infant at six months.

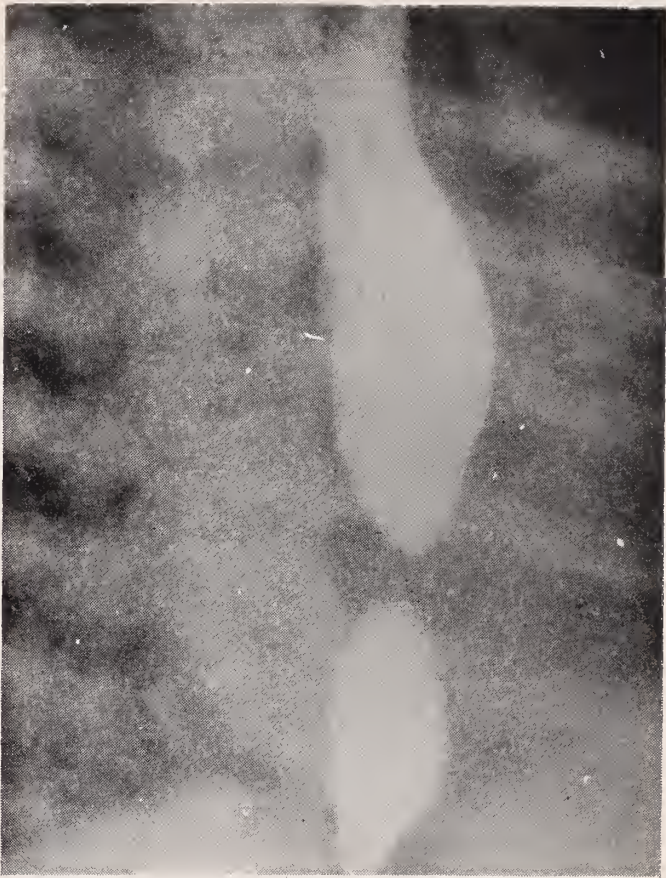


Figure 3
Note extreme narrowing of Esophagus well above the Cardia.

gastrostomy tube did not function well. Irrigations could not be aspirated. X-rays of the stomach using gastrograffin showed no obstruction of the pylorus by the mushroom catheter. A Foley catheter was substituted and no further difficulty was encountered. The catheter was used to initiate feedings by drip, with aspiration prior to each feeding to see if the stomach emptied. In the case of an infant with cystic fibrosis, as in this child, the use of a nasogas-tric tube would be a serious mistake. All respiratory difficulties should be avoided. It was felt that the gastrostomy significantly aided in the recovery of this sick newborn.

Case Report Two

A. T. W., a full term male infant, was born on December 23, 1961, at Fort McPherson Army Hospital, Atlanta, Georgia. At the age of 11 days he underwent pyloromyotomy. Following this, he developed pneumonia on two separate occasions, requiring hospitalization. Because of persistent difficulty with swallowing milk and then saliva, a barium swallow was done and revealed a stricture or narrowing of the lower esophagus about 3-4 cms. above the cardiocosophagal junction (Sec Figure 3), and the pylorus was patent. The infant continued to have difficulty and he was transferred to the Henrietta



Figure 4
Barium Swallow prior to discharge.

Egleston Children's Hospital, Atlanta, Georgia, at the age of four months. Esophagoscopy revealed firm esophageal stenosis in the lower esophagus. Dilatation with urethral woven filiforms and followers was unsuccessful. An attempt to use woven tip Bougies resulted in a perforation of the esophagus. This was closed within one hour. At the thoracotomy, the esophagus was noted to be markedly thickened with muscular hypertrophy. A Stamm Gastrostomy was done. The infant made a remarkable recovery (See Figure 4), and was discharged on feedings by gastrostomy only. He was seen two months from the time of his discharge at which time he was taking all of his milk by mouth and had gained five pounds, but cereals and meat gruel were still being given per gastrostomy (See Figure 5).

Comment

This very sick infant was helped considerably by the presence of a gastrostomy, both to decompress the stomach to prevent the regurgitation of gastric secretions upward and into the thorax and media-

stinum while healing of the esophageal perforation took place, and also to resume adequate nutrition.

The technique for Stamm type gastrostomy is well illustrated and described in the surgical textbooks, so it will not be dwelt upon here. It is well to mention that a large bore mushroom catheter with the entire tip cut off is the best type to use. General or local anesthesia may be used. The catheter should not be placed on suction but on straight drainage. Irrigations of normal saline 5-10 cc's every two to three hours should be done. The saline should flow freely in and out. When used for feeding purposes, aspiration before each feeding will tell the status of gastric emptying. The tube can be taped upright so that gravity will keep the contents from leaking out. This will also serve as an outlet valve in case of vomiting. If one is in doubt as to the position of the catheter, or whether a reinserted catheter is within the stomach, then an X-ray using gastrografin or other radio-opaque substances should be done to establish its exact position. This was done on Case One.

Summary

A case is made for gastrostomy, of a temporary nature in the infant undergoing surgical intervention for intestinal obstruction. The serious nature of gastric dilatation and other sequellae was pointed out. The advantages of gastrostomy were described.



Figure 5
Case Two, A.T.W., Age: seven months. Gastrostomy tube in place. Taking p.o. feedings well.

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COMMON NON-ULCERATIVE CONDITIONS OF THE GASTROINTESTINAL TRACT

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■ ***In order to treat any of these conditions properly, it is essential to rule out organic disease of the gastrointestinal tract.***

THE PURPOSE of this paper is to describe certain common complaints referable to the gastrointestinal tract which are of non-ulcerative etiology. The books, monographs, and papers describing the cause, symptoms, diagnosis and treatment of peptic ulcer and ulcerative colitis are too numerous to begin to list. However, when one attempts to investigate the conditions listed below, one finds relatively very little written about them. These are cited as conditions rather than diseases. They are described as the common conditions seen every day with varying frequency in the author's office. Starting above and downward through the gastrointestinal tract these are:

1. Globus hystericus.
2. Cardiospasm.
3. Esophagitis.
4. Aereophagia. (air swallowing and belching)
5. Large gas bubble in fundus of stomach (with or without eventration).
6. Duodenitis.
7. Pylorospasm.
8. Gastrointestinal hypermotility.
 - a. Small bowel.
 - b. Large bowel.
 - c. Colonic spasm.
 - d. Emotional diarrhea.
9. Hepatic and splenic flexure syndrome.
10. Rectal spasm (Proctalgia Fugax)

While one may think of other associated condi-

tions, these ten are most frequently seen. These conditions are rarely mentioned in the standard texts on gastroenterology. In fact, even the text books are few and far between. In 1946 Bockus¹ wrote his monumental three-volume treatise. Nothing is then available until 1953 when Portis² wrote his contribution. Then in 1958 Jones³ in England and Andresen⁴ published texts on gastroenterology. A careful perusal of these well written texts fails to bring forth the specific information in usable form which I shall try to set down in the following paragraphs. No effort will be made to didactically outline the physiology of the gastrointestinal tract which is well documented in the above listed texts as well as many other places so easily available. A style of presentation will be attempted which may be of value to others when confronted with these problems in every-day practice.

Rule Out

In order to treat any of these conditions properly it is necessary to rule out the organic diseases of the gastrointestinal tract. One should take a very careful history and do a thorough, painstaking physical examination. It must be remembered that this patient is already apprehensive and fearful of the presence of the worst diseases, particularly cancer, that have been discussed by well-meaning friends and reassurance is most necessary. The routine laboratory procedures are done as well as a chest X-ray and electrocardiogram. In addition, one must do an X-ray evaluation of the gastrointestinal tract

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Figure 1

Cardiospasm, showing the dilatation of the esophagus above the obstruction and fluid level.

including heavy barium study of the esophagus, three hour, and when indicated, 24 hour follow-up of the barium meal.

Globus Hystericus

The patient presents himself with a complaint of a "lump in my throat," or "I cannot swallow." When given plain water and then barium the patient is seen to swallow without difficulty but still "feels the lump." The physician must rule out Plummer-Vinson's syndrome,⁴ cancer of the esophagus, pernicious anemia, and vitamin B-complex deficiency. When this has been done, the exact nature of the cause of this condition must be explained to the patient. Usually the explanation that there is no organic disease present and that the lump is felt because of tension, plus the reassurance that nothing serious can occur as a result of this, will be sufficient even without sedation for the average patient.

Cardiospasm

(Figure 1) This syndrome is more complex and the result of long standing, severe cardiospasm is dilatation of the esophagus with fibrosis of the cardiac sphincter. This discussion shall be restricted to the early symptoms and treatment so the later disabling disease may be prevented.

The patient usually states he feels a pain, a tightness, even an inability for food to pass a point in the region of the ensiform process. On further questioning he will say that if he is nervous or upset the sensation is more severe. On fluoroscopy with heavy barium and in very early cases, with use of the Valsalva technique (i.e. straining against a closed glottis immediately upon taking the barium swallow) the spasm of the cardiac sphincter is demonstrated.

Many of the early cases may be helped with explanation and reassurance. The farther advanced cases will require a bland diet with the omission of cigarettes and coffee and the use of mild sedatives and/or tranquilizers.

When one deals with a more advanced case where actual obstruction occurs, dilatation with esophageal bougies after esophagoscopy will be helpful. It is my experience that this patient will usually require psychiatric consultation to get permanent relief even after dilatation sufficient to permit passage of a No. 30 bougie. These patients can be helped by the psychiatrist and are usually willing and anxious to accept this therapy.

Esophagitis

This is mentioned for completeness as it is relatively uncommon. It is usually seen in this sense as a complication of cardiospasm, pylorospasm, and hiatal hernia. The patient complains of substernal

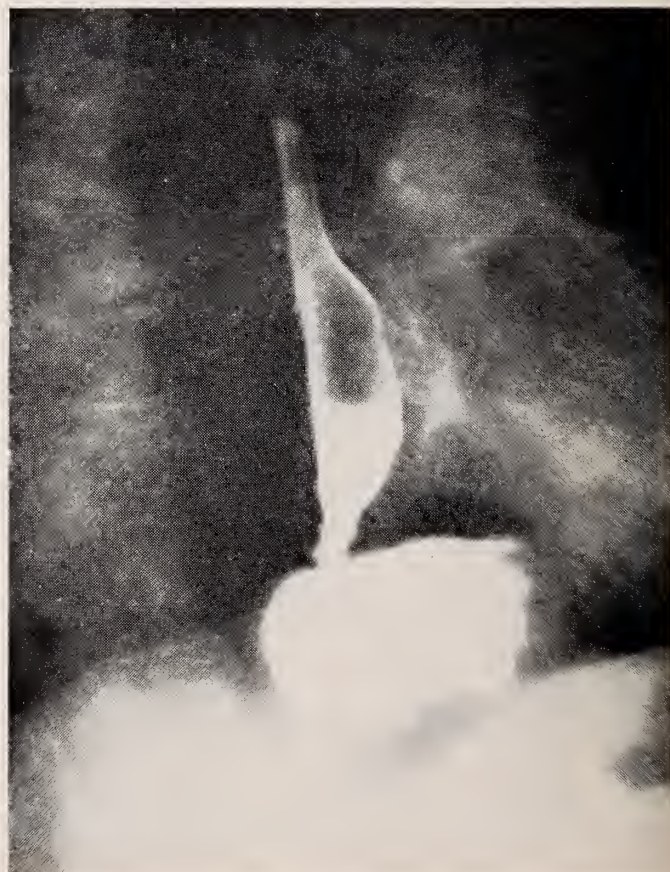


Figure 2

Esophagitis, showing the irregularity of the distal end of the esophagus.

burning and the occurrence of some vomitus. The symptoms are not necessarily associated with ingestion of food but may occur at any time.

On fluoroscopy and X-ray there is irregularity of the distal end of the esophagus. Palpation upward in the epigastric region will elicit tenderness. Andresen believes this type of disturbance is secondary to either beginning digestion of food above a cardiospasm or regurgitation through the cardiac sphincter secondary to severe pylorospasm.⁵ Treatment of the primary spastic condition above or below, plus bland diet, Aluminum hydroxide gel and mild antispasmodics and sedatives will usually bring about rapid healing.

Recently, Wyeth Laboratories has introduced a product, Oxethazaine, in alumina gel with magnesium hydroxide, which is available as Oxaine-M. This is a mild topical anesthetic agent in an amphoteric base. Two drams are administered undiluted ten to 15 minutes before each meal, at bedtime and as needed for discomfort. This gives almost immediate and gratifying relief and permits the patient to eat comfortably.

Aereophagia

Air swallowing causes the patient to complain of belching immediately after eating or drinking. The loud noisy expulsion of gas through the mouth gives relief from a fullness in the epigastrium and/or a pressure in the chest. This annoying condition which

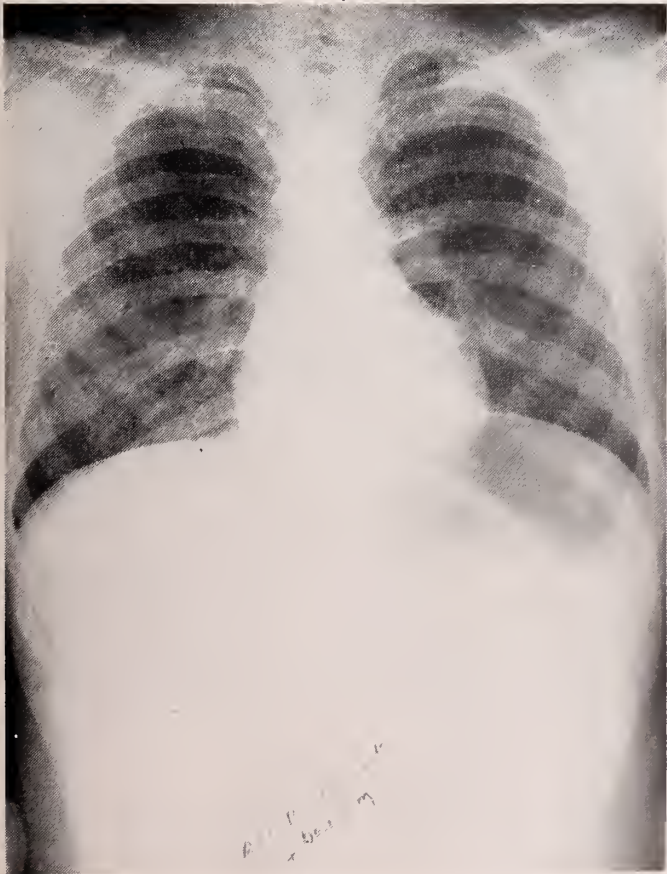


Figure 3
Gas bubble

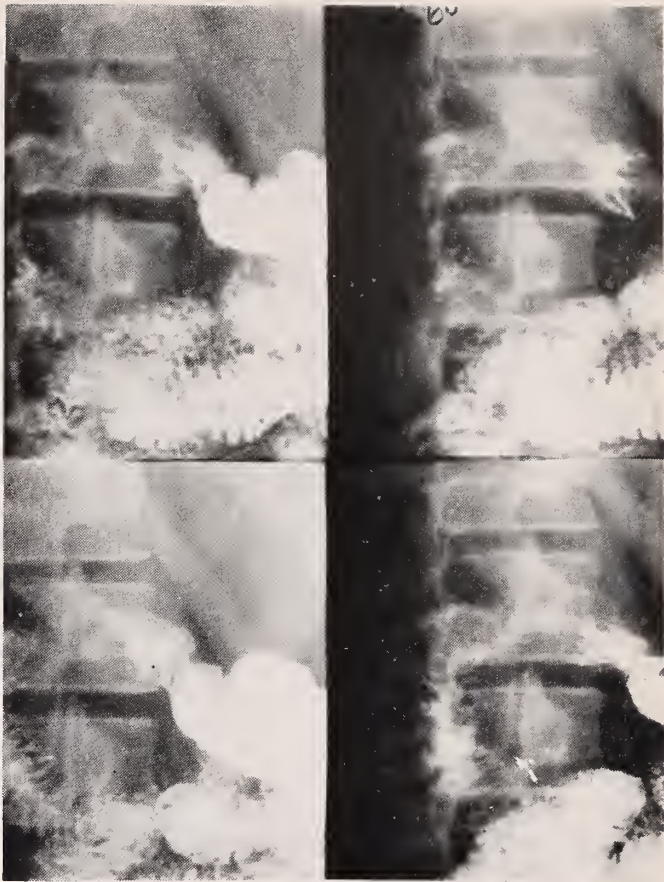


Figure 4
Duodenitis — Incessant irregularity of the duodenum.

is so common, is only mentioned in passing and no specific therapy is outlined in the standard texts.

The air swallowing is usually seen in tense individuals who eat too rapidly; talk while they eat, usually business; gulp down large amounts of liquid to wash down partially chewed food; annoy all their associates with resounding “burps;” take any patent indigestion pill; and complain to their physician about their “indigestion.”

Here again the patient needs to be reassured and to have the situations causing this to be explained to him. He is then advised to eat more slowly; never talk with food in his mouth; to relax at meal time; never wash down partially chewed food with liquids; and on many occasions I have advised the patient to drink all fluids through a straw. These precautions will usually relieve this annoying habit.

**Large Gas Bubble in Stomach
(with or without eventration)**

(Figure 3) This is mentioned here because of its frequency in practice and its absence in this connection from the texts.

The patient complains of a severe pain “under the heart.” It usually comes on about an hour after eating and most frequently when the patient is driving or otherwise just sitting still. The discomfort is often relieved simply by standing up or stopping the car and walking around for a moment.

The patient may be placed under the fluoroscopic screen and given a warm carbonated drink (Our Georgia drink is Coca Cola). In the presence of eventration the fundus can be seen to raise the thinned diaphragm high in the left chest, and if no eventration, the large bubble in the fundus rises to a lesser degree, but the symptoms are reproduced in both cases. I have rarely seen a patient not "cured" by this dramatic demonstration which he is allowed to see and feel while back of the fluoroscopic screen.

Duodenitis

(Figure 4) The symptoms of duodenitis are quite similar to those of duodenal ulcer and this condition is thought to be a precursor of ulcer. If one is aware of the presence of this irritation in the duodenum he may be able to prevent the formation of a true ulcer.

The patient presents himself with vague epigastric discomfort, even burning pain which comes on sooner after eating than typical ulcer pain. The patient usually does not vomit nor is he awakened at night.

Under the fluoroscope a tender, very irritable cap is noted. On film no crater or niche can be demonstrated nor is any constant deformity seen. The duo-



Figure 5

Gastrointestinal Hypermotility. The barium is in the rectum in three hours.

denal cap changes form in practically every view.

Treatment will be discussed with the next subject.

Pylorospasm

While pylorospasm is often associated with duodenal ulcer or gall bladder disease with secondary irritability of the pylorus, it more frequently occurs as a result of tension. In this rapid pace of existence tension abounds and pylorospasm is very common.

The patient complains of a "knot in his stomach," which comes and goes. It is annoying but not disabling. One usually finds spastic phenomenon above and/or below in the gastrointestinal tract associated with this.

Pylorospasm is an X-ray diagnosis. The pylorus is actually seen to go into spasm. This spasm may last from a fleeting second to 15 minutes or even more. It may even cause retention of the barium meal in the stomach at the three-hour examination.

It is important that one recognize duodenitis and pylorospasm, because with prompt, proper treatment the patient may get immediate relief and the formation of an ulcer may be prevented.

My custom is to have the patient eat a bland, modified ulcer type of diet. It need not be so strict as in an actual ulcer but it should be soft. No fresh fruits or raw vegetables are allowed. Seasoning is held to a minimum. The patient is given anti-acids, anticholinergic drugs, and appropriate mild sedatives or tranquilizers.

Usually after explanation, reassurances, and the routine outlined above, the symptoms disappear quickly and within six weeks most patients may gradually resume a normal diet and omit the medication.

I always caution these patients that at the first sign of a return of symptoms or if they are placed in any pressure situation they should immediately resume the diet and medications for a few days or until the situation has cleared.

This method has been universally successful in my patients who cooperate.

Gastrointestinal Hypermotility

- a. Small bowel.
- b. Large bowel.
- c. Colonic spasm.
- d. Emotional diarrhea.

The old cliché, "The intestinal tract is the mirror of the emotions," was never more true than in this condition. Patients are seen again and again with complaints of:

1. "Cramps in stomach."
2. "Pains across lower stomach."
3. "Rumbling and cramps in my gut."
4. "Frequent intermittent loose bowel movements."

5. "Mucous in stools."
6. "Can't sleep at night because of noises in my stomach."
7. "Food comes through undigested."
8. "As soon as I eat I have to have a bowel movement."
9. "Loss of weight and fatigue."
10. "Something's got to be done for me, please."

Here, I make a fervent plea to all physicians. Please do not ever be guilty of telling these poor uncomfortable, miserable people, "You are just nervous. Relax and you will be all right." Again, I say, one must take a careful detailed history. Time must be taken to go into the patient's problems, worries and anxieties whatever they may be. Then a careful physical examination is done. Here, one finds very little except (1) a mild tachycardia, (2) wet hands and feet with dripping axillae, (3) the sensation of hyperactivity of the abdominal contents, (4) slight to severe tenderness on palpation over the descending colon and sigmoid, (5) the distal descending colon and sigmoid colon are firm and have the consistency and sensation as if one were palpating a garden hose.

The laboratory studies, including routine blood and urine, stool cultures, and examination for ova and parasites as well as sigmoidoscopic are invariably negative, if the emotional etiology of the diagnosis is correct.

On fluoroscopy one frequently finds cardiospasm and pylorospasm also. The barium shoots rapidly through the proximal small intestine and the stomach empties very quickly, but at the three hour follow-up of the barium meal, occasionally there is a small amount of barium still in the stomach secondary to the pylorospasm. However, the barium has usually filled out the large bowel around to the rectum and always to the sigmoid colon. When 24-hour follow-up studies are done, the over-active colon will be empty of barium but there may be spastic segments with retained barium.

If the patient has diarrhea he will usually have it during the day or the active hours. Emotional diarrhea *almost never* awakens the patient at night. Everyone knows what organic diarrhea does to the patient's—not to mention the physician's sleep. Often the diarrhea will come immediately after a meal. After several days of this the patient finds mucous strings in the stool and this is what causes him to seek medical aid. I have many patients who react to bad news, anxiety or tension, with diarrhea. Students before an examination are a well-known example of transient, hypermotility of the bowel with resultant diarrhea.

The treatment must be individualized but in all

cases the patient is reassured of the absence of organic disease. The situation causing these symptoms is carefully explained. He is shown the X-rays. He is allowed to palpate his "garden hose" sigmoid and he is told that "his case is not hopeless." It is my practice to give these patients a low residue bland diet similar to the ulcer regime. I have become very fond of the long acting medication, particularly "Combid Spansules" which are Smith, Kline and French's combination of ten mg. of Compazine (prochlorperazine) and five mg. of Darbid (isopropamide) given every 12 hours. I also use paragoric and a kaolin and pectin mixture to further control cramps and the immediate diarrhea.

The symptoms subside very quickly. The mucous disappears from the stool. The patient gains strength and regains the lost weight because the food which passed through undigested is now affording nourishment. One even may need a mild lubricating or non-laxative fecal softener such as dioctyl sodium sulfosuccinate (Doxinate, Lloyd Bros., Inc.) to prevent constipation.

I insist on at least six weeks of this routine and even three months in some cases. Usually by this time the tenderness is gone from the sigmoid colon area. The bowel movements are regular and the patient is comfortable. I then allow one to gradually resume vegetables and fruits by adding one new item



Figure 6

Colonic Spasm (Under the fluoroscope, this area relaxed and filled well).

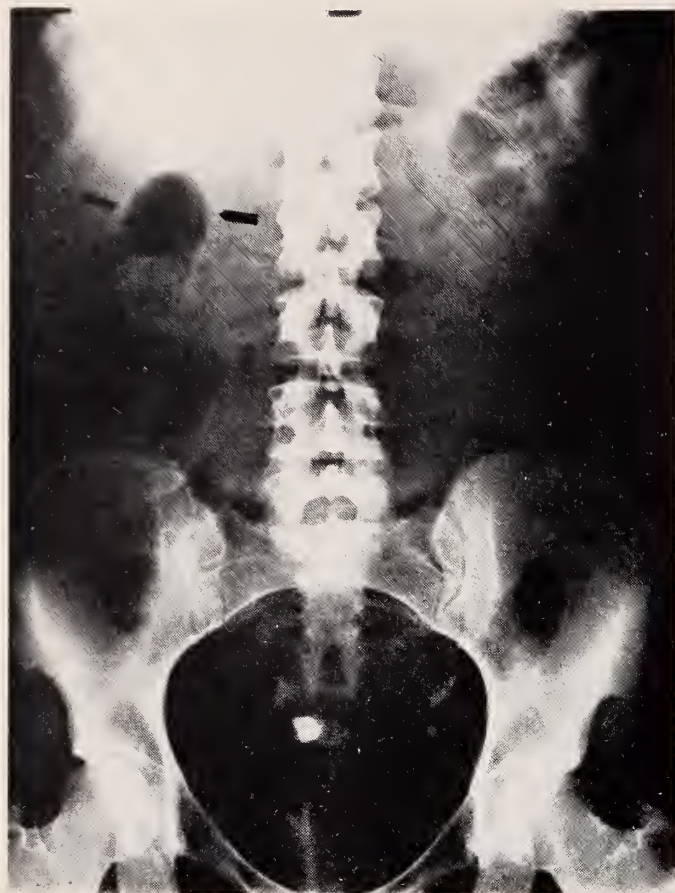


Figure 7

Hepatic and Splenic Flexure Syndrome in same patient.

each day just in case any one particular food causes discomfort. The anticholinergic drugs and tranquilizers are gradually reduced, then omitted.

The patient is warned that if he should be placed in a tension situation at any time he should immediately resume the bland diet, medication, and try to understand what is causing the tension.

My prize patient once went into true diarrhea every time she lost her maid but in the last few years many maids have quit but "Combidi" and a thorough understanding have prevented a recurrence of the diarrhea.

Hepatic and Splenic Flexure Syndrome

This condition is less commonly seen but must be considered when the patient complains of a sense of almost bursting pain in the abdomen. This may be limited to either the right or left side of the abdomen. The pain is severe while it lasts, but it may disappear completely without treatment.

On physical examination one will find hyperresonance over either the ascending or descending colon without generalized abdominal distension. There is no nausea or vomiting and often the patient will have a bowel movement especially in the splenic flexure syndrome, with complete relief.

The diagnosis cannot be made by barium enema. It is made if one is lucky enough to take a flat film

of the abdomen while the patient is in pain. Then the ascending colon may be seen to be dilated by gas to the hepatic flexure and no abnormal gas is seen beyond this point. In the splenic flexure syndrome the descending colon and sigmoid are distended with gas to the proximal ascending colon. There is no abnormal gas proximal to this point. The descending and sigmoid colon may be clearly seen to be in severe spasm.

The fear engendered by the severity of the pain increases the spasm which is thought to occur at the anatomical area of the "U" turn of the large bowel.

The patient must again be reassured. In the hepatic flexure syndrome simply lying on the left side will often permit the "loop" to "open up" and give immediate relief. It may be necessary to teach the patient to gently massage the gas around and past the hepatic flexure.

In the splenic flexure syndrome a small enema will give quick relief. One must remember that the other organic lesions of the large bowel have been ruled out before this diagnosis is made.

Rectal Spasm

An infrequently seen but annoying situation is rectal spasm. In 1935 Thaysen⁵ coined a term, proctalgia fugax. This means fleeting rectal pain. In this condition the patient complains of a sudden severe cramping in the rectum which only lasts for a few seconds. It is thought to be due to gas suddenly over-distending the rectum.

Jackman⁶ advises that one take an enema immediately. He further states that nitroglycerin may be necessary. However, it is my belief that reassurance and the natural reflex action of the distended rectum will give adequate relief.

These conditions have been presented to bring the attention of the clinician to certain situations which arise with more or less frequency in the everyday practice. However, they either are not mentioned at all or are described very briefly in the standard texts on Gastroenterology. Therefore, it has been my earnest desire to be of help in an unorthodox, personal presentation based on the past 23 years of active internal medical practice.

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THE USE AND ABUSE OF ADRENAL STEROIDS IN THE PRACTICE OF MEDICINE

Stanley M. Silver, M.D., *Augusta*

■ *Unfortunately some patients receive corticosteroids in lieu of a diagnosis.*

IN THE FALL OF 1948, a significant milestone in the science and art of medicine was reached when Hench and his associates first administered cortisone to a patient with rheumatoid arthritis. The dramatic response noted brought a new concept of therapeutics to medicine and, in time, has added truth to Dr. Harvey Cushing's prophecy which was delivered at the Lister Memorial Lecture in 1930. At that time, he predicted that endocrinology or, for our purposes, "corticosteroid therapy" would "sweep aside many long cherished views of disease in a tidal wave as momentous as that which swept over medicine at the end of the last century upon the discovery of the bacterial origin of the infectious disorders."

Tidal Wave

At present, this "tidal wave" has swept into virtually every phase and field of medicine. The uses of adrenal steroids are, in reality, only two in number. The first of these is in the study of patients with Cushing's disease or the adrenogenital syndrome where they help to distinguish between tumor and hyperplasia of the adrenal cortex. The second major category deals with therapy. There are three indications for the use of steroids in treatment. The first of these is the physiological replacement therapy of Addisonian or adrenalectomized patients. The second indication is in adrenogenital patients who may need suppressive therapy. This syndrome is believed to result from a variety of enzymatic defects in the adrenal cortex. This causes large amounts of androgens to be formed at the expense of cortisone production. Thus virilization becomes the prime clinical com-

plaint. The use of steroids will decrease urinary ketosteroid output and arrest the virilization. The final application is the most extensive and most important of the three. It deals with a wide variety of medical conditions among which are skin diseases, asthma, connective tissue diseases, ulcerative colitis, nephrosis, blood dyscrasias, pulmonary diseases, the arthritides and cardiac diseases. To improve and combat these conditions, the seven commonly used steroids in clinical practice are cortisone, hydrocortisone, prednisone, prednisolone, methyl prednisolone, triamcinolone and dexamethasone.

Action of the Hormone

A troublesome problem which may arise from steroid therapy is due to the exaggerated physiological action of the hormone. The typical "Cushingoid" features may often follow prolonged steroid therapy. Another action of the hormone which has gained more and more attention is its tendency to produce diabetes. "Steroid diabetes" probably results from the hormone's ability to increase gluconeogenesis, decrease peripheral glucose utilization and antagonize the action of insulin.

The anti-inflammatory properties of the steroids are perhaps their most useful action; however, it has been shown that the increase in anti-inflammatory activity in some analogues is paralleled by an increase in mineralocorticoid activity. The mineralocorticoid activities are characterized by increases in retention of salt and water, and increased excretion of calcium, phosphorus and potassium. The obvious difficulties inherent in the use of these compounds in

cardiac, hypertensive and osteoporotic patients go without mentioning. This remarkable anti-inflammatory activity has been well incriminated in regards to its ability to mask infections and to reactivate old, healed tuberculosis. In addition, it has been noted that steroids decrease the body's immunity or antibody response to infectious agents.

Decision is Easy

The decision to use steroids is often easy to make. However, the decision to stop that therapy is not always easy and is fraught with a certain amount of danger. The ability of steroids to suppress adrenal activity is the basis for their use in diagnosis. Therefore, the discontinuation of steroids is not a matter of stopping medications suddenly but of gradually withdrawing them. Many studies have shown that a decrease in urinary steroid excretion can be demonstrated after as little as 50 mgs. of cortisone per day. A recent report has shown that a significant degree of adrenal suppression or adrenal unresponsiveness can be demonstrated for intervals as long as six weeks following a mild course of steroids for a period of seven days. Consequently, after large steroid dosages or small doses over a period of time, rapid reduction of dosage can lead to adrenal cortical insufficiency and even shock during stressful situations such as surgery, infections and trauma. To obviate this very real danger, one should probably institute additional steroid therapy in such a patient when exposed to stressful situations. A good rule of thumb is, that if more than 50 mgs. of cortisone (or equivalent dosage of another steroid) has been given for a week or more within six months of the stress, then additional "covering" steroids should be given.

As indicated above, the pharmacological use of steroids is evident in the management of various diseases in virtually every system of the body; therefore, it can be concluded that untoward reactions may become manifest in any of these systems. Perhaps the most widely publicized complication is the development of peptic ulcer in patients undergoing steroid therapy. This is a particularly vicious and treacherous complication. It is characteristically asymptomatic until the threat of exsanguination alerts the physician to this problem. Recently, a syndrome of necrotizing arteritis allegedly due to steroids has been described. These patients are usually being treated for rheumatoid arthritis. While on steroids, they develop muscle weakness, arthralgia, fever and Raynaud's phenomenon. The clinical course that follows is one of rapid deterioration with a syndrome not unlike polyarteritis nodosa.

Other rarer complications of steroid therapy have been noted with increasing frequency. The first of these to be discussed is the aseptic necrosis of bone which can occur secondary to steroids. This usually affects the hip or tibia. The defect involved is due to increased vascular fragility. Focal hemorrhage and aseptic necrosis occur due to mild trauma. The normal processes of tissue repair are unable to handle the situation. This defect is probably due to cortisone's suppressive effect on osteoblastic activity.

The literature has been studded recently with reports of even rarer complications of steroid administration. The interesting finding of subcapsular cataracts in patients receiving moderate doses of steroids for a period of time is as yet without explanation. Likewise, the development of a nodular panniculitis following within two weeks after cessation of therapy is also unexplained. Apparently, histological studies have shown these nodules to represent a different process from those seen in other more common conditions (i.e., rheumatic nodules, Weber-Christian Syndrome and erythema nodosum). The final unusual complication to be mentioned is the unexplained, increased intracranial pressure which may develop during treatment with the steroids. This can lead to convulsions, nausea, vomiting and other symptoms reminiscent of brain tumor.

Diagnosis Must Precede Treatment

It is axiomatic in medicine that diagnosis must precede treatment. This rule is probably overlooked so that some patients receive corticosteroids in lieu of a diagnosis. Therefore, it is possible that the failure to make a diagnosis, the failure to use conventional or established treatment and a desire to please the patient with a dramatic response account for many of the common abuses of corticosteroid administration. Perhaps, as in the use of the Digitalis preparations, the physician should select one or two particular compounds and become well versed in their administration. He should understand these compounds in regard to their glucocorticoid and mineralocorticoid activities. Specific idiosyncrasies such as the quadriceps wasting of triamcinolone should be at the basis of his knowledge. A realization that steroid complications can range a gamut of reactions from troublesome obesity to frank psychoses are essential to the rational use of these agents. Above all, he must remember that the art of treatment was never better expressed than by the Swiss physician, Paracelsus, in the sixteenth century when he wrote, "a physician should be a servant of nature, not her enemy. He should be able to guide and direct her in her struggle for life and not by his unreasonable influence throw fresh obstacles in the way of recovery."

MEDICARE REVIEW BOARD REGULATIONS

The State Medicare Review Board for Georgia held its annual meeting at which time recommendations were made concerning the revision of policies and regulations for the review boards relative to the Dependents' Medical Care Act (Medicare). These proposals were then acted upon by the Executive Committee of Council of the Medical Association of Georgia. Minutes of the State Medicare Review Board Meeting, Executive Committee of Council Meetings, and the final approved revised Medicare Review Board Regulations are published herein for information. The purpose of this article is to communicate information to participating physicians so they may know and understand the policies and regulations established for the operation of Medicare Review Boards in Georgia.

STATE MEDICARE REVIEW BOARD MEETING MINUTES

THE ANNUAL MEETING of the State Medicare Review Board for Georgia was called to order at 2:00 P.M., September 30, 1962, in the MAG Headquarters Building, Atlanta, Georgia.

Those present included W. Vernon Skiles, Chairman, State Review Board; August B. Turner, Member, State Review Board; P. C. Shea, Chairman, Atlanta Review Board; Paul Teplis, Member, Atlanta Review Board; Joseph B. Mercer, Member, Brunswick Review Board; W. W. Payne, Member, Brunswick Review Board; P. C. Graffagnino, Chairman, Columbus Review Board; Remer Y. Clark, Jr., President of the 7th District Medical Society, representing the Rome Review Board; John T. Mauldin, Secretary, Medical Association of Georgia and adviser to Medicare Headquarters Office; Mr. James E. Baker, Medicare Administrator; Mrs. Joyce Butler, Medicare Assistant Administrator; and Mrs. Mary White, of the Medicare Staff.

Reading of Minutes

Mr. James E. Baker was called on to read the minutes of the State Review Board Meeting, November 12, 1962. These minutes were approved as read.

Report of Medicare Office

Mr. Baker gave a statistical report covering the cumulative claim record from March, 1961, through August, 1962, including the number of claims received, returned, rejected, and sent to the review board.

Formulation of Review Board Policies and Regulations

A letter was read by Dr. Skiles from the Council of the Medical Association directing the State Medicare Review Board that:

1. "All previous 'ground rules' be wiped out;
2. New regulations be set up;
3. Exact recourse be outlined and publicized to physicians;
4. State officers conduct themselves as impartial administrators and see that no abuses be allowed, but that the method of changing regulations be specifically outlined and no arbitrary action taken;
5. Executive Committee should have all changes presented to

it and be specifically approved by the Executive Committee;

6. All minutes of State Medicare Review Board meeting be kept so each subsequent Administrator can know of previous actions."

The proposed Medicare Review Board Regulations were reviewed and discussed. The following motions were made:

1. (Mercer-Payne) Sec. A, Par. 2. That review boards be set up on a district basis. Any district which cares to merge with another district may do so upon recommendation by District President or local Review Board, and with the approval of State Medicare Board.
2. (Clark-Mercer) To make District Medical Society President an ex-officio member of local review board. Motion carried.
3. (Mercer-Payne) A Review Board will submit two names, the President of the District Medical Society will appoint one of his choosing. Failed to pass.
4. (Mauldin-Teplis) Sec. C, Par. 4. State Medicare Board shall be composed of the members of the local review boards. This board shall act on all policy changes and contract changes and make recommendations to the Executive Council. Motion carried.
5. (Mauldin-Teplis) Sec. D, Par. 2. Omit all references to specialties of medicine. Include one member, but one only, who is in active practice of Ob-Gyn care. Motion carried.
6. (Clark-Mercer) Sec. E, Par. 2. After a local review board reaches its decisions and this decision is satisfactory with the physician submitting the claim, the claim is then submitted to Washington for final adjudication. Motion carried.
7. (Mauldin) Sec. B. Medicare director through representative of Council has the authority to request that a claim be adjudicated by a higher board after written notification to the board and physician involved. Failed to pass.
8. (Mercer-Payne) Administrative personnel may call attention to apparent problems or abuses that may arise and that these be referred to the State Medicare Board for appropriate action after notification of the physician and the local board involved. Motion carried.
9. (Mercer-Payne) Sec. F. Add item 2. That the State Medicare Board meet at least annually and at the request of the chairman, executive committee, or written request of five members of this board. Motion carried.
10. (Clark-Payne) Sec. G. Add item 8. Any physician whose claim is in question may, upon his request, attend any level board meeting. Motion carried.
11. Dr. Mercer moved that these rules be published in the *Journal of MAG*. Motion passed.

Change of Contract Discussion

1. Payment of out-of-state physicians
Refer to Executive Committee to handle as they can. (Turner-Payne)
2. Outpatient Care
Concur with Council that no enlargement of Program be recommended.
3. Increase in Psychiatric Fees
Chairman of State Medicare Board to ask Georgia Psychiatric Association to make recommendations for increase in fees.

Adjournment

Motion was made and seconded that the meeting be adjourned at 5:00 P.M.

**EXECUTIVE COMMITTEE OF COUNCIL
EXCERPT OF OCTOBER 11, 1962**

Medicare Report

Dr. Vernon Skiles, Chairman, State Medicare Review Board, and Mr. James Baker, Medicare Administrator, were asked to make a report on the State Medicare Review Board Meeting held September 30, 1962. Dr. Skiles reviewed the actions taken by the Board, with the suggested changes in the rules and regulations, subject to the approval of the Executive Committee of Council. The items on which Executive Committee took action are as follows:

(1) On motion (Dillinger-Simonton) it was voted that the State Medicare Board Chairman should continue to check the Medicare claims, and if there are any discrepancies in the claims, to refer them to the Executive Committee of Council. This procedure is to be followed because the Executive Committee is financially responsible for the Medicare Program in Georgia.

(2) At the State Medicare Review Board meeting it was suggested that the new rules and regulations be published in the *Journal of MAG*. On motion duly made and seconded it was voted to publish these rules and regulations as amended.

(3) After discussion regarding the appointment of an Appeal Board, which had been suggested by the State Medicare Review Board, on motion duly made and seconded, it was voted that the Executive Committee should be the Appeal Board, and that the suggestion made by the Medicare Review Board for the appointment of an Appeal Board be abolished.

(4) On motion duly made and seconded it was voted that the State Medicare Board should be composed of members of Review Boards at all levels.

(5) On motion duly made and seconded it was voted to approve this report with the amendments made in the new rules and regulations as stated above.

**EXECUTIVE COMMITTEE OF COUNCIL
EXCERPT OF NOVEMBER 4, 1962**

Medicare

Mr. Baker, Medicare Administrator, stated that in setting up the new Medicare boards, the State Review Board became a Review Board and the State Medicare Board became the policy suggesting group; therefore, it was necessary to take action on the following:

(a) Review Board Chairman Appointment—After discussion, it was voted that the Chairman of the Review Board should be the Chairman of that Board and also Chairman of the State Medicare Board.

(b) Appointment of State Review Board Members—On motion (Mauldin-Simonton) it was voted to appoint a representative of a small hospital to serve on the State Review Board, and to appoint the three other members already serving on the board. On further motion it was voted that the Medicare Rules and Regulations should be changed to read "the State Review Board should be composed of three or more members."

(c) On motion duly made and seconded it was voted to approve the Rules and Regulations with amendments as stated above.

Medicare Review Board Regulations

A. ESTABLISHMENT OF REVIEW BOARDS

1. Review boards shall be established according to directions emanating from the Office for Dependents' Medical Care, Office of the Surgeon General, Department of the Army.
2. There shall be a review board in each area of Georgia corresponding with the District Medical Societies of the Medical Association of Georgia. And district which cares to merge with another district may do so upon recommendation by District President or local Review Board, and with the approval of State Medicare Board.

3. These review boards shall be commonly known as:

- 1st — Savannah
- 2nd — Albany
- 3rd — Columbus
- 4th —
- 5th — Atlanta
- 6th — Macon
- 7th — Rome
- 8th — Brunswick
- 9th — Cumming
- 10th — Augusta

4. There shall be a three man review board in each district, with the district society president serving additionally as an ex-officio member, rotating yearly; one man added each year; the senior man to serve as chairman; two men recommended yearly by the review board and one appointed to the review board by the appointing authority who shall in each case be the appropriate District Medical Society President. If at any time the review board fails to function properly, a new board shall be established by appointment of the MAG district president. This determination shall be made, after request by the Executive Committee, by a vote of a majority of the State Medicare Board Members. In the event that a new board is appointed, the review board members shall decide among themselves who shall serve as chairman. In case of resignations, the review board will submit two (2) names, as in the case of rotation, to the president of the appropriate MAG District Medical Society who in turn will appoint one of the named men to the review board. If the review board chairman does not wish to rotate at the end of a year, the board may continue as constituted for one additional year.

These policies are established for the review board members to rotate yearly so that each man shall at one time serve as chairman and no person will be required to serve more than three years on a review board.

B. PURPOSE OF THE REVIEW BOARDS

The primary purpose of review boards shall be to give a medical evaluation and adjudication to all special report cases which require submission to a review board.

The claims which shall be sent to review boards may include, but shall not be limited, to the following categories:

- (1) Non-routine cases
- (2) Procedures which are listed in the Manual as payable by special report only
- (3) Procedures which are not identified in the Medicare Manual
- (4) Procedures for which the fee charged is in excess of the fee authorized in the Medicare Manual, provided a special report is submitted
- (5) Sterilization procedures
- (6) Supplemental skills
- (7) Surgical procedures marked "E" in the Medicare Manual normally are not

considered allowable except when they are medically indicated, are not elective, and not performed solely upon request of the patient or for cosmetic purposes

- (8) Cases where extra antepartum (in excess of 13) or postpartum more than (1) visits are required for maternity care
- (9) Other services of an unusual degree
- (10) Administrative personnel may call attention to apparent problems or abuses that may arise and that these be referred to the State Medicare Board for appropriate action after notification of the physician and the local board involved

C. TYPES OF REVIEW BOARDS

1. Local Review Boards

There shall be ten (10) local review boards, as set out above, which shall consist of three physicians appointed from the district in which the review board is located, and the president as an ex officio member.

2. State Review Board

This board shall normally be the final authority on all adjudicated claims. This board shall rotate the same as local boards and shall be composed of three or more members.

3. Appellate Review Board

This board shall review claims only in cases where the other two boards have previously adjudicated those claims and the physician involved is dissatisfied with their decision or rejects their conclusion.

4. State Medicare Board

The State Medicare Board shall be composed of the members of review boards at all levels. This board shall act on all policy changes and contract changes and make recommendations to the Executive Committee. The chairman of the State Review Board shall also serve as chairman of the State Medicare Board.

D. COMPOSITION OF REVIEW BOARDS

1. Each board shall consist of at least three physicians whose term of office shall begin in the month of January and end in the month of January. This means that any physician appointed during the intervening months shall serve until the following January and shall then serve a full term beginning in that month.
2. The review board should at all times have one member, but only one, who is in active practice of Ob-Gyn.
3. Each board should ask consultants in the appropriate specialties to sit with them when the claim being adjudicated involves a special area of medicine not represented on the board.
4. No review board member at any level may sit in adjudication of his own claim, nor shall any physician in practice with a physician whose claim is being adjudicated sit in adjudication of such claim. (e. g. partner or associate)

5. Members of the State Review Board shall be appointed by the Executive Committee, exclusive of its own members. The members of this board must be chosen from within a reasonable communicable distance of MAG headquarters. It is the intent that this board shall have a representative from a smaller community and/or hospital.

6. The Executive Committee shall be the Appellate Review Board.

E. PROCEDURE IN ADJUDICATING CLAIMS

1. All claims for review shall be initially submitted by the Medicare office to a local review board.
2. After local review board reaches a decision all claims shall then be sent to the State Review Board chairman who shall check them. If there are any discrepancies in the claims, he shall refer them to the Executive Committee of Council. If the State Review Board chairman approves the claims and the physicians involved approve of the decision of the local review board, the claims shall then be submitted to Washington for adjudication.
3. After a claim is returned to the Medicare office by a Review Board, if that board has made any adjustment in the amount of the claim, then the physician involved shall be notified by a signed card of the adjustment made. No action will be taken on that claim by the Medicare office for a period of 14 days. If the physician involved is not heard from within that period to make known any objections he has, then the claim shall be forwarded to Washington for final adjudication. Any physician who is not satisfied with the determination made by the local review board and the State Review Board, may ask to have the Appellate Review Board consider his claim. This request must be in writing and contain substantial and reasonable grounds for the submission of a claim to the Appellate Review Board. In that the Appellate Review Board is composed of the members of the Executive Committee, the decision of that board shall be final in so far as claims are adjudicated by review boards in Georgia.
4. All claims, after final decision by a Georgia Review Board, shall be forwarded to Washington for final review as required by contract.
5. In cases where a claim has not previously been submitted to the Appellate Review Board but has been submitted to Washington, and Washington makes an adjustment on that claim, and where the physician is dissatisfied with the resulting adjustment of a claim, he may still request that his claim be considered by the Appellate Review Board by following the procedures outlined above. If the Appellate Review Board concurs with the Washington adjudication, then the decision is final. The physician will be notified and the claim will be paid in that amount. If the review board

**Whatever happened
to handkerchiefs?**

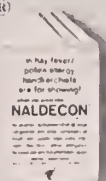


Remember when handkerchiefs were used for stuffy or runny noses? *That was before Naldecon.* Naldecon lets your head-cold patient breathe the way he should. Through the nose. Honest relief that lasts up to 8 hours with one sustained-action tablet. (When you need it, even *half* a tablet retains the sustained-action feature.) The counterbalance between *two* antihistamines and *two* decongestants* usually gives excellent results—seldom causes overstimulation or sedation. Keep handkerchiefs for showing. Prescribe Naldecon.

*Each tablet contains phenylephrine HCl 10 mg., phenylpropanolamine HCl 40 mg., phenyltoloxamine citrate 15 mg., chlorpheniramine maleate 5 mg.—half in the outer layer, half in the sustained-action core. Each teaspoonful (5 cc.) of Naldecon Syrup contains the equivalent of one-half tablet.

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SPECIAL ARTICLE / Continued

disagrees with the Washington adjudication, then the above procedures, regarding notice to the physician and time for objection, will be followed and the claim returned to Washington for their review. After this decision, the claim will be paid in the amount decided upon by Washington.

6. The claims of State Review Board members will go directly from the local review board to the Appellate Review Board and shall not be considered by the board of which they are a member.

F. MEETINGS

1. To further the policy that no claim shall be out of the Medicare office for a period longer than 30 days, each local review board and the State Review Board must meet at least once a month if there are claims to be adjudicated. The chairman of a board may call meetings more frequently than that when deemed necessary by the presence of a number of claims at that board needing adjudication. Claims submitted to the Appellate Review Board will be adjudicated by those members when meeting regularly in conjunction with the monthly Executive Committee meetings.
2. The State Medicare Board shall meet at least annually and at the request of the chairman, executive committee, or written request of 5 members of this board.

G. GENERAL PROVISIONS

1. Correspondence
All correspondence from physicians on a claim which must be adjudicated shall be directed to the Medicare Office and a copy is to be kept on file there.
2. Additional Information
If a review board requires additional information before they can properly reach a conclusion, the letter requesting additional information from a physician should be signed by the chairman of the board and a copy submitted to the Medicare office. If the board wishes to remain anonymous, then the chairman should request that the Medicare office secure the additional information and submit it to the board.
3. Adequacy of Special Reports

Any special report in which information is inadequate for proper adjudication and additional information cannot be obtained within 30 days after requests have been made for such information and/or for a hospital transcript, will be considered in the light of the available information and adjudicated on that basis or rejected if deemed necessary. In any case, special report claims not adequately supported, will not be sent to Washington as a last resort, but will be resolved on a local level and then forwarded for Washington approval.

4. Travel

The Medicare administrator shall be authorized to travel throughout the State upon request or when deemed necessary to discuss the operation of review boards or to explain generally Medicare regulations.

5. Remuneration of Review Board Members

The only provision for remuneration of review board members is that they may be reimbursed for any travel done in conjunction with and service on a review board. This shall be paid at a rate paid other members of the Medical Association.

6. Basis of Fees

The review board should keep in mind, in deciding upon the amount payable, that the physician should base his fees in accordance with a family having an income of \$4,500 a year.

7. Form of Adjudication

All review board adjudications must be submitted in writing, in letter form, to the Medicare office.

8. Any physician whose claim is in question may, upon his request, attend any level board meeting.

H. ADOPTION OF THESE RULES

These rules and regulations, after approval by the Executive Committee of Council of the Medical Association of Georgia, shall become effective immediately. The review boards presently in existence will continue as constituted to the expiration of their terms.

I. AMENDMENTS

These rules and regulations may be changed upon recommendation of a majority of all review board members present at a State Medicare Board meeting and upon approval of the Executive Committee.

DRUG SAFETY INFORMATION AVAILABLE TO DOCTORS

To help answer patients' questions concerning drug safety, the Pharmaceutical Manufacturers Association has made special leaflets on the subject available to doctors for their waiting rooms.

The leaflet, entitled, "Safety of Prescription Drugs," was prepared by a group of prominent industry scientists who assimilated previous studies and wide personal experience in compiling the information. It is particularly helpful in overcoming public misconceptions

which arose as a result of the thalidomide publicity.

A major portion of the pamphlet is devoted to a chronological outline of steps in testing drugs before they are marketed. It cites the use of nearly nine million animals by pharmaceutical researchers in 1961 and explains how toxicity tests are performed and what information is obtained.

Copies of the folder are available without cost from the association's headquarters, 1411 K Street, N.W., Washington 5, D. C.

1962-63 CALENDAR OF MEETINGS

State

October 23, 1962-March 14, 1963—Series of Postgraduate Courses presented by the Medical College of Georgia's Department of Continuing Education: February 12-14—"Growth and Development—Management of Common Behavior Disturbances;" March 12-14—"Gynecologic Problems in Private Practice."

February 17-20, 1963—Atlanta Graduate Medical Assembly, Atlanta Biltmore Hotel, Atlanta.

March 11-13, 1963—Second Annual Postgraduate Course, "Cardiology for the Pediatrician," sponsored by the Department of Pediatrics, Emory University School of Medicine, Grady Memorial Hospital Auditorium, Atlanta.

March 28-30, 1963—Annual Meeting of the Georgia Society of Ophthalmology and Otolaryngology, General Oglethorpe Hotel, Wilmington Island, Savannah.

May 5-8, 1963—109th Annual Session of the Medical Association of Georgia, Aquarama, Jekyll Island, Georgia.

Regional

October 1962-November 1963—Fourteen Postgraduate Courses offered by the University of Tennessee College of Medicine: February 13-15, 1963—"Emergency Surgery in the Case of the Injured Patient;" March 7-8, 1963—"Urinary Tract Diseases—Diagnosis and Treatment."

December 26-31—American Association for the Advancement of Science, Philadelphia, Pa.

January 20-25, 1963—American Academy of Orthopaedic Surgeons, Americana Hotel, Bal Harbour, Miami Beach, Fla.

February 14-16, 1963—American Society of Clinical Pathologists, New Orleans, La.

March 6-9, 1963—American Orthopsychiatric Association, Inc., Shoreham Hotel, Washington, D.C.

March 18-21, 1963—Southeastern Surgical Congress, Americana Hotel, Miami Beach, Fla.

March 22-27, 1963—North American Clinical Dermatology Society, Diplomat, Hollywood, Fla.

March 24-28, 1963—International Anesthesia Research Society, The Americana, Bal Harbour, Miami Beach, Fla.

March 29-31, 1963—American Otorhinologic Society for Plastic Surgery, Fountainebleau Motor Hotel, New Orleans, La.

April 1-5, 1963—Thirty-sixth Annual Spring Congress in Ophthalmology and Otolaryngology sponsored by the Gill Memorial Eye, Ear, Nose and Throat Hospital, Roanoke, Va.

April 17-20, 1963—Sixteenth Annual Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, West Va.

National

January 18, 1963—American Society of Facial Plastic Surgery, Hotel Elysee, New York City.

January 21-25, 1963—The American College of Physicians Postgraduate Course No. 8, "Diseases of the Blood Vessels and Problems of Thromboembolism—Treatment and Diagnosis," Cornell University Medical College and New York Hospital, New York City.

January 24-26, 1963—Symposium on Genetics and Heart Disease sponsored by the Heart Association of Southeastern Pennsylvania, Hotel Sheraton, Philadelphia, Pa.

February 2-6, 1963—Congress on Medical Education, Palmer House, Chicago, Ill.

February 6-8, 1963—American Academy of Occupational Medicine, Sheraton-Lincoln Hotel, Indianapolis, Ind.

February 7-9, 1963—Society of University Surgeons, Seattle, Wash.

February 28-March 3, 1963—College of American Pathologists, Rice Hotel, Houston, Tex.

February 28-March 4, 1963—American College of Cardiology, Ambassador Hotel, Los Angeles, Calif.

March 17-22, 1963—American College of Allergists, The Americana, New York City.

March 24-29, 1963—American College of Allergists Graduate Instructional Course and Nineteenth Annual Congress, Americana Hotel, New York City.

March 29-31, 1963—American Society of Internal Medicine, Brown Palace Hotel, Denver, Colo.

March 29-April 4, 1963—American Academy of General Practice, Chicago, Ill.

June 16-20, 1963—American Medical Association Annual Meeting, Atlantic City, N. J.



Medical Education's Role In The Crisis of Medical Manpower

DOUBT NO LONGER EXISTS that we are facing an extreme shortage of physicians during the next ten years. Although new medical schools are being built and shorter curricula are being used experimentally, the situation will get worse before it gets better. The man most affected by this shortage, the practicing physician, must begin to take a close look at certain trends and help to effect a more ready solution to this problem. If it is left in the hands of those not inclined towards the private, individual practice of medicine, the tendency of the government to control us all will be hastened.

World War II brought about many changes. Among these was a sudden increase in the number of residencies offered for training in the various specialties. Some years later it became apparent that many more internships and residencies had been created and approved than could be filled by medical school graduates. Many of the programs provided were not adequate to qualify an individual for the specialty involved. Properly so, there has begun an investigation of all these programs involving the setting of standards for proper training.

Affiliations

In September 1961, hospitals offering approved residencies numbered 1,324. Of these, 972 were not affiliated with medical schools and 352 were so affiliated. The former offered 12,752 positions, the latter 15,604 positions. In the non-affiliated group, 357 hospitals reported the presence of a full-time director of medical education and 493 reported the presence of a part-time director. Out of interest in promoting the quality of education in these non-affiliated institutions has grown the organization known as the Association of Hospital Directors of Medical Education. Begun in 1956, this organization now has 154 active members and is rapidly increas-

ing in size. It is the purpose of these individuals to organize and administer their hospital's program in medical education. The importance of these programs is evidenced by the fact that many physicians now study as long in hospitals to qualify for medical practice as they do in medical school to qualify for the M.D. degree. In the field of intern-resident education and in the interest of continuing education for the physician in practice, each of these directors is concerned with utilizing all hospital facilities (physical and human) to develop an attitude of inquiry, evaluation, and teaching which eventually leads to improved patient care.

Thesis

The thesis on which departments of medical education are formed is that the internship and residency years should be spent in preparing a recent graduate for the practice of medicine. The progress of medicine depends a great deal on the physicians who adapt the findings of medical science to the patient. We need more physicians today who personally deal with patients and their particular circumstances, rather than an increasing number of basic scientists who by their very nature and background are not motivated to clinical practice. It would seem to follow that the teacher best qualified to accomplish the goal of training a man for practice is the physician in active practice, if he is given the proper framework in which to train the intern and resident. About twenty years ago the majority of clinical faculty members in the universities consisted of men in active practice, with the possible exception of the chief of the department. Primarily, all teaching in the graduate (medical school) years and in the postgraduate (internship and residency) years was accomplished by active practitioners of medicine. This pattern has given way to the predominance in universities of full-time faculty members many of whom have never practiced

medicine outside the confines of university centers. Gradually, participation in the teaching of students, interns, and residents by active practitioners of the profession has diminished to the point of being nonexistent in some areas.

No Indication

This is in no way intended to indicate that full-time professors and associates are undesirable in the medical school. However, since 90 per cent of patient care is carried on in hospitals not associated with universities, it is apparent that the preparation of a man for the practice of the profession is not taking place where men active in such practice predominate. The trend is towards centralization of postgraduate training in university centers where only ten per cent of actual medical care takes place. There is no disagreement that a faculty is necessary and best prepared to guide the student toward obtaining the M.D. degree. Is it logical to assume that this same group should bear primary responsibility in directing the processes by which these new doctors learn the skills necessary to practice medicine properly?

Changing Pattern

The changing pattern of medical teaching since World War II has been brought about by several factors. First, and probably most important, has been the abrogation by the private practitioner of his duty to set the standards of patient care in this country. All too frequently, his attention to his own practice, his recreational activities, his ancillary business interests and his family obligations have taken him away from activities in medical schools and hospitals. This has allowed non-practicing physicians or lay personnel to set the standards for medical care. Attempts to modify standards which seem unwarranted have met with failure or extreme frustration so many times that the private practitioner has succumbed and followed these patterns with an all too quiet acquiescence. The second factor has been the financial plight of the medical schools. In attempting to solve this problem, many schools have depended heavily on governmental research grants. The natural sequence of this has been an ever increasing emphasis on research in the medical schools. In many instances there are more researchers in a given department than there are professors. In some instances it appears that all energies are directed toward training researchers and teachers rather than toward training physicians for practice. Thirdly, the government has shown its ever present tendency toward control by insisting that men paid by research grants carry out no other activity (teaching, patient care, etc.) except where that activity is directly related to the research project in-

volved. Many other economic and social factors have entered into these changes, all of which have combined to leave us extremely short of physicians.

The time in which we find ourselves is being called the "Era of Crisis in Medical Manpower." By 1970 it is predicted that even if all doctors work 24 hours, seven days per week, the basic needs of the population will not be met. The problem will not be solved by building new medical schools requiring ten years from their starting point to graduate the first class. It can be solved by considering a cooperative endeavor on the part of all physician groups in the nature of a crash program. Certain concepts, or more correctly, opinions, must be changed if proper utilization of facilities is to take place. The reader is encouraged to remember the magnitude of the problem facing medicine in this country—the extreme shortage of all medical personnel—in hopes that he will sublimate his personal impressions to the need for drastic measures in correcting the deficit. A suggested plan is sketchily outlined below:

1. Double the size of every freshman medical class in the country within the next 12 months, preferably at the beginning of the next school year.

In most schools the preclinical and clinical professors spend only about one-half of the year in the classroom. It is feasible that they could be persuaded to teach two "classes" each year instead of one. If space is at a premium, then some new construction might be necessary, but not of the magnitude of building an entire school.

2. As the clinical years approach the time of containing the double class (three years away) the extra number of students could be placed in existing hospitals for clinical clerkship.

Because of their location, few medical schools would find it difficult to utilize the facilities of nearby institutions for the junior and senior year clerkships. As indicated above, the establishment of branch offices in these institutions through a department of medical education would assure proper direction during this clerkship period. Rotations could equalize time spent in each type hospital.

3. Through the directors of medical education in these ancillary institutions, the level of supervision of clinical clerks desired by the parent university could readily be arranged.

At this point the practicing physicians in these hospitals must (and probably will) be willing to assume a critical role in the education of the medical student. Such attitudes and duties could readily be supervised by the educational department in each institution.

4. Co-sponsor with the participating hospitals a program of internship, residency, and continuing education correlated to meet the needs of all groups in that community.

In many instances the duplication of teaching activity is such that its overall effectiveness is weakened. Such a cooperative program as might be envisioned from the above could serve to strengthen all phases of medical education.

In closing, I quote from an article in the October 13 issue of the *J.A.M.A.* entitled, "The Declining Clinical Tradition," written by a psychiatrist, Dr. Jurgen Ruesch, of the University of California School of Medicine. He states ". . . we need high-grade professionals—researcher, doctor, and teacher all in one. Funds for education have to be made available at an increasing rate so that permanent faculty and hos-

pital positions can be created. Funds have to be given to an institution outright; dependency upon government or industry must be eliminated; soft money has to become hard money. . . . Only when a core group of independent professionals counterbalances the short-sighted and temporary fashion trends initiated by politicians, the military, advertisers, or civil servants can a nation hope to survive."

To those who are interested in pursuing this subject further, it is recommended that 15 minutes be taken to read this article and ponder what part you may play in helping to solve this dilemma.

Lester Rumble, Jr., M.D.
Director of Medical Education
St. Joseph's Infirmary, Inc.
Atlanta, Georgia

EDITOR'S NOTE: *The above suggested solutions to an increasingly serious problem represent one viewpoint. Other viewpoints from our readers will be welcomed.*

Was Your Voice Heard Too Little or Too Late?

"THE BEST DEFENSE IS A GOOD OFFENSE." Whoever coined the phrase may have been contemplating the playing fields of Eton or the first Battle of Manassas. But regardless of which, if either, this axiom has general application in just about every field of endeavor. Certainly it is true in the political world, as both winning and losing candidates for public office will tell you.

The medical profession has been on the defense for a good number of years now, without any appreciable offense to minimize its losses. While it is true that we have not lost many major battles, it remains that as long as we stay in essentially a defensive position, we can never actually win—at best we can only postpone.

To develop winning ways we need a winning vehicle harnessed to the offensive requirements of modern day politics. Such a vehicle is available and needs only a driver willing to play in the big league.

The vehicle: GaMPAC, GEORGIA MEDICAL POLITICAL ACTION COMMITTEE.

If the medical profession is to take the offensive, it must organize for effective political action. No one can go it alone. It must be a joint effort. And either we shall master the ways of political action or we shall be mastered by those who do.

The Georgia Medical Political Action Committee was formed for just this purpose. Your Medical Association, bound by law, cannot participate actively and directly in politics. Even though a candidate may openly advocate principles at odds with the best interest of the medical profession, as a corporate body, MAG is powerless to take truly effective counter political measures. Hence, the need for a political organization outside the framework of MAG, but one whose views parallel those of organized medicine.

This is where GaMPAC gets into the act. GaMPAC's main purpose, indeed its only purpose, is to elect good men to public office. Boiled down to its essentials, this means effectively and intelligently putting the collective weight of doctors behind the candidacy of those men who possess the philosophy, the talent, and the integrity to run the world's biggest business: Government.

There is a job to be done and GaMPAC is the mechanism by which it can be done. However, it must have members and a great number of them. Otherwise, it is a phantom organization, a toothless tiger.

GaMPAC was not organized for the benefit of anybody's favorite candidate. It will function only for the good of the medical profession, which in this instance we feel is synonymous with the public good.

Selection of candidates to be the beneficiaries of GaMPAC assistance will be based on practical and intelligent appraisals gathered from every possible source—with primary emphasis placed on information received from the local source.

As previously stated, MAG cannot participate directly in partisan politics. It can, however, urge its members to affiliate and participate aggressively in

the affairs of the Georgia Medical Political Action Committee—and it does just that.

GaMPAC was conceived as the most expeditious answer to a problem desperately in need of solution. By its nature it will always be on the offensive, and in the final analysis such offensive tactics will prove to be medicine's best defense. Support GaMPAC with money and manpower. It will pay handsome returns in the years ahead.

Clinical Use of Glycerolized Frozen Blood

HUMAN BLOOD CAN NOW BE PRESERVED for at least six years and probably much longer. The practical method which exists consists of glycerolizing red blood cells, quick-freezing them, and storing them at -80°C . Such blood can be rapidly thawed, deglycerolized, reconstituted, stored for up to two weeks in a standard refrigerator, and then successfully given to patients. Clinical results in several thousand cases have been excellent, and the reaction rate has been lower than with standard bank blood.

The cells are separated from the plasma and glycerolized in a Cohn (ADL) fractionator, which is a sterilizable, closed-system centrifuge. The same equipment is used for deglycerolization and reconstitution of the blood. The red cells are re-suspended in 60 cc of five per cent human albumin media, 250 cc of five per cent albumin media, or 200 cc of frozen plasma from the same blood, depending upon whether packed red cells, volume replacement, or whole blood is required. Thus, the blood can be "tailored" to fit the needs of the recipient.

Frozen heparinized blood can be used as a priming

fluid for extracorporeal circulation. Rare types of blood can be stockpiled for future use. Individual patients who are to have elective surgery can donate and stockpile their own blood for use when required.

A stockpile of rare types is maintained in deep-freeze at the Chelsea Naval Hospital and by the Protein Foundation in Boston. After clearance with the American Association of Blood Banks Reference Laboratory, these can be obtained for use in emergencies by local hospitals. The Military Blood Bank in Chelsea will thaw the blood, deglycerolize and reconstitute it, and send it by air in a refrigerated container.

It is anticipated that many larger hospitals throughout the United States will eventually secure the necessary equipment and trained personnel to make stockpiles of deep-frozen blood available locally.

References

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2. Sproul, Mary T.: Clinical Use of Frozen Red Cells, *Archives of Surgery*, 81:No. 1, p. 169-151.

That Christmas Day May Ever Come

*"Forget, forgive, for who may say
that Christmas day may ever come
to host or guest again."*

William Henry Harrison Murray

A PERSON IS RATHER hard put to say anything different about Christmas. It's finally here, it's too commercialized, we're going to do our shopping earlier,

"Yes, Virginia, there is a Santa Claus," and *Time Magazine* chastising the U.S. Post Office for issuing a Christmas stamp with a wreath instead of some

symbol of the religious aspect of the season on it. Several other "seasonal" things come to mind, depending on how it affects one individually, but basically the same "raisons de Christmas" are there. It's all been said and thought about before.

But perhaps each one of us wishes each year, when the time again rolls around, that he will find a unique something in this particular season. Something different, a new kind of feeling, a new way of giving, or a personal way of glimpsing into the real heart of the matter. The real meaning of what Christmas should mean, the birthday of a Saviour.

This particular season will find no one scavenging for the meaning, or a reason to make the spirit more vivid, for the fact that we are still here and not blown to bits by something nuclear is a blessing in itself.

Last month at a Chamber of Commerce meeting one of the members was asked to give the invoca-

tion. Having lived through a week of uncertainty and cliff-hanging tension, the man could say little that had not already been uttered by thousands. So he said very simply and without reservations, "Thank you, God, for letting me be here today," and sat down.

Each of us has probably uttered this occasionally, after what we personally consider to be a traumatic experience, but then maybe it hasn't been said often enough or for the right reasons.

This Christmas, 1962, no one should have to seek diligently a reason for a special kind of season, for it is there for all to see and feel. We are still here. And that in itself should be reason enough to feel the real spirit of Christmas.

It's not commercial, it can't be shopped for, it doesn't come down the chimney, and it won't be found in the symbol on a stamp. It's just there. The intangible to thank God and celebrate a Saviour's day, and the real reason to sincerely wish everyone a Merry Christmas.

MAG REPRESENTATIVES ATTEND REORGANIZATION MEETING

Representatives of the Medical Association of Georgia appeared at the general hearings conducted by "The Citizens Committee on Reorganization of the State Comptroller General's Office" at the State Capitol Building, Atlanta, Georgia, on November 14, 1962. These hearings are conducted under the auspices of Comptroller General Elect, Mr. James Bentley. Excerpts from the Association recommendations are printed below.

"It is our privilege and pleasure to appear before this Committee in behalf of the more than 3,000 doctors of medicine in the State of Georgia comprising our membership.

"As physicians, our interest in the conduct of the Comptroller General's Office stems from our responsibilities to our patients in providing adequate health care. More specifically, we are concerned with the patient's problems relative to voluntary pre-paid health insurance. As you know, the Comptroller General's Office is charged with the duty of regulation of both the insurance company underwriting such coverage and of the insurance agent who makes this type coverage available to the public. We seek means to further improve and perfect this mechanism and to promote public confidence and acceptability of the principle of voluntary pre-paid health insurance in order to give even greater protection to the citizens of Georgia. To this end we are cooperating with our patients, insurance companies and insurance agents in advising with them on this subject.

"Our purpose today is to make certain recommendations for the consideration of this Committee and the Comptroller General Elect in the sole interests of our patients' health care. While these recommendations

are general in nature, we would be pleased at any time to counsel with the Comptroller General's Office on specific ways and means of their implementation. The Medical Association of Georgia therefore makes the following recommendations:

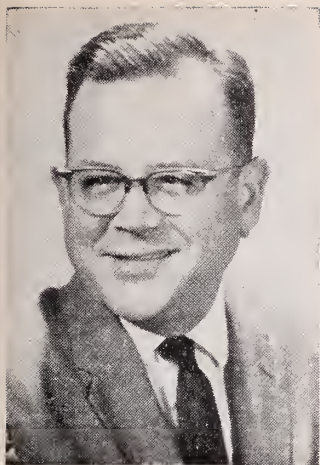
(1) "That a permanent Health Insurance Liaison Committee of physicians representing the Medical Association of Georgia be established by the Association for the sole purpose of maintaining liaison with the Comptroller General's Insurance Department. This Committee would be available to advise with and provide counsel for the Insurance Department on medical matters that affect health insurance.

(2) "That the Comptroller General's Office establish a continuing program of public education and information for the citizens of Georgia to better inform the public about choosing the best type of health care insurance to fit their individual needs.

"(3) That the Comptroller General's Office establish within the Insurance Department an effective procedure for the investigation and regulation of misrepresentations and abuses of health care insurance by insurance companies, insurance agents, policy holders and physicians, hospitals and nursing homes.

"(4) That the Comptroller General Elect consider a study by the Insurance Department to evaluate and make recommendations on the possibility of advising with health insurance companies about their adoption of standardized health insurance forms, i.e.: Attending Physicians Statement form; Claims forms; etc.

"We are prepared to discuss these brief recommendations with this Committee, the Comptroller General Elect and the Insurance Department."



"THE SHOE IS ON THE OTHER FOOT"

AS MOST OF YOU probably know by now, I have been a patient in the hospital. Recently I went to see a friend of mine for a physical and he lowered the boom on me. I had been feeling dragged out for about a month and when he suggested I turn in for a check-up, I did not protest too much. Of course, having only been on the giving end of this sort of thing, I did not know what I was getting into. It seems that somebody thought that he could feel a mass in my epigastrium, and that really lit off the fuse. After a week of being stuck and bled, starved, X-rayed, and enemaed half to death, my doctors finally came in one morning and said, "We can't find anything — but we think you ought to be explored."

I am sure that we doctors do not realize the mental anguish that goes along with this sort of thing. Whether it is worse to be ignorant of the possibilities and then fear the unknown, or to know what the score is and what the possibilities are, I do not know. I only know that one can find no peace of mind in a situation like this outside of a firm faith in the Lord. An old low country Negro once said to me, "De mon wot meke you — gonna look atter you."

Now that it's all over, the discomfort and inconvenience are really a small price to pay for knowing that things are all right. But, somehow an experience like this changes one's perspective. One appreciates one's friends more, one is more thankful for the good things of life. The opportunity to work, to help others, seems more satisfying. One's family seems closer and the sunset looks a little prettier. The trout strike harder and a good bird dog on a point makes one's heart beat a little faster.

Above all, one is more thankful for the real meaning of Christmas. In this spirit, I wish you all a Merry Christmas and a Happy New Year.

Alex W. Goodwin
President, Medical Association of Georgia



PSYCHOSOMATIC GYNECOLOGIC PROBLEMS IN MARRIAGE

J. Ray Rommer, M.D.,* *New York, New York*

GYNECOLOGIC PSYCHOSOMATIC SYMPTOMS often associated with the avoidance of sexual activity are problems that literally go to the very roots of life itself. Their contribution to the unhappiness of individuals and families is obvious. Less well known is the significance of these ailments as factors leading to divorce.

Psychosomatic gynecologic syndromes may be divided into the following categories:

1. *Painful syndromes* including pelvic pain, dyspareunia, and vaginismus.
2. *Purely functional and non-painful syndromes* including leucorrhea, amenorrhea, oligomenorrhea, hypermenorrhea, abortion, and irregular menstrual periods.
3. *"Defeminizing" syndromes* such as sterility, frigidity of various grades, coitus-phobia, and vaginismus.¹

While unconsciously these symptoms are primarily employed for emotional relief, they also provide the patient with a secondary gain by allowing her to remove herself emotionally from a difficult position or situation. With her symptoms she is often able to control those activities and desires of her husband which would normally include her as a participant. She can thus avoid such undesirable tasks as housework and sexual demands, as well as pregnancy and motherhood.

At first her husband sympathizes and worries. He abstains from sexual activities, helps with the housework and lightens her day in other ways. After a time, however, his tolerance for her troubles is reduced as his own conflicting emotional needs begin to create anxiety.

At the beginning he may try to console and bribe

her with small niceties in an effort to manipulate her to "health." However, these soon give place to arguments. He may then feel driven to seek extra-marital adventures because of his wife's attitudes ("physicians have implied there is nothing really wrong with her!"). The patient (i.e., the wife) on the other hand, may experiment with other partners in an effort to prove her femininity, obtain narcissistic or ego-satisfying supplies, or to punish her husband. ("He is mean and pays no attention to me!").

Thus, psychosomatic gynecologic problems can lead to marital incompatability, adultery and offenses against the community's moral standards. In addition, broken homes—whether actually broken by frank separation, or spiritually broken by frank incompatability—are prime factors in juvenile delinquency.

In treating patients with any psychosomatic problem, investigation often reveals underlying psychosexual factors. Physicians have "relieved" psychosomatic *gynecologic* symptoms, only to have the individual begin to "ail" in another somatic area. This may come about as follows:

Complaint Produces Arguments

From her past experiences the patient has learned that a complaint pointing directly to the gynecological sphere often produces arguments, especially when the subject of sex or pregnancy is introduced, so she takes her symptoms underground. She now focuses attention on symptoms elsewhere, making these the major complaints, while she relegates to second place those in the gynecological area. Now the major symptoms may represent the patient's psychosexual difficulties without bringing attention to them. She is now able to accomplish the same emotional gain as she would have with her undisguised gynecological symp-

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tomatology without arguments. This process may be a conscious, partly conscious, or an unconscious phenomenon. Thus, emotional factors normally instrumental in the production of gynecologic symptomatology may, by displacement or symbolization, give rise to symptoms elsewhere in the body. A psychosomatic ailment may, in effect, be caused by a condensation of emotional factors that would normally produce psychosomatic symptoms in several areas of the body.²⁻³

Anxiety and other chronic intense psychological states such as fears, anger, hostility, or long-standing unresolved conflicts are factors that produce or contribute to these symptoms in the following manner:

1. Certain patients may exhibit severe gynecologic symptoms that subside without relieving the emotional conflicts that produced them. The same conflict may produce symptoms elsewhere, and these are then really representative of gynecologic symptoms.

2. Gynecologic symptoms may never develop, but the emotional conflict that would usually produce them, instead gives rise to persistent symptoms in other areas of the body. These serve the purpose of

the unconscious and at the same time avoid feelings of "defeminization" that often disturb some of these patients.

For example, constant gastric pain, nausea or headache will just as effectively prevent sexual intercourse as will vaginismus or dyspareunia. Yet, the patient can say, "I am a woman, I want to, but I can't because of—."

3. The patient may have gynecologic symptoms that are unrelieved, but to strengthen the attitude of sexual isolation, symptoms in other areas of the body develop secondarily.

In treating the first two groups, medication may be employed for relief of anxiety and/or pain, in conjunction with psychotherapy. The "defeminizing" syndromes respond *only* to psychotherapy, since medication would only re-inforce the symptoms.

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Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

THE SERPENT AND STAFF OF AESCULAPIUS

The relief sculpture on the front of the Peachtree Medical Building in Atlanta was designed and executed by Mr. Julian Harris on commission and is intended to represent a portion of the medical emblem composed of historically authentic elements. Reproductions of this sculpture, in miniature, are depicted in the lighted ceiling of the Peachtree floor lobby.

The American Medical Association adopted as its official emblem a single snake entwined around a knotty staff of Aesculapius on a shield of red superimposed on a green cross.

Physicians often inadvertently refer to the emblem as a caduceus, but it is not. A caduceus is a straight wand around which two snakes are entwined. Although some medical organizations use it as their emblem, it does not carry any implication as a symbol of medicine.

The caduceus emblem represents the wand and wings of Hermes, Messenger of the Greek gods, who separated two snakes that were fighting. The "Peace-Maker" connotation of the emblem resulted in its use by non-combatant military personnel, including the medical corps.

Aesculapius was idealized originally as the human family doctor; later as the hero-physician of Homeric Greeks; and finally was apotheosized as the patron of the art of healing.

Legend has it that Aesculapius was attending a patient when a serpent crept into the room. Aesculapius killed it, but a second snake entered the room, put herbs into the mouth of the dead serpent and revived

it. According to legend, this so worried Pluto over the possible de-population of his realm that he persuaded Zeus who feared Aesculapius might render all men immortal, to destroy him. He was killed by a thunderbolt.

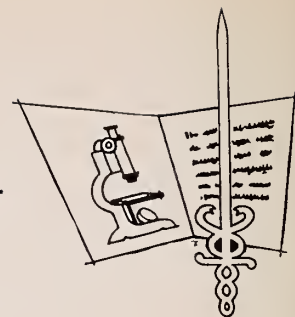
The knots in the staff of Aesculapius symbolize the "knotty" problems of medicine and the serpent typifies wisdom. The snake is also a symbol of healing, since it sloughs off its skin periodically and thus renews its life.

At Epidaurus, Greece, was erected the first Aesculapian temple, a combined residence for the healers and hospital for the sick. The serpents had the run of halls and dormitories and were used in actual therapy. Ancients relate that the serpents were trained to come when called by music and whistling, and that they licked the wounds of sleeping lethargic patients. Also, that the serpents were carried by both Greek and Roman armies along with Aesculapian healers and surgeons.

These temples spread throughout Greece and the Roman empire, being located at spas and other healing locales. The healing serpent is one of the Colubridae family, his two scientific names having as the middle word of each "Aesculapius." These serpents are indigenous below the Alps but are found today only in regions where archeologists have uncovered remains of Aesculapian temples.

Hygeia was the daughter of Aesculapius. Hippocrates was descended from Aesculapius, the 19th generation.

Donald W. Singleton, M.D.



THE USE OF NON-HORMONAL CHEMOTHERAPY IN THE TREATMENT OF SOLID TUMORS

John P. Wilson, M.D., *Atlanta*

THE IDEAL ANTI-CANCER AGENT would be a drug which would have a specific cytotoxic effect on cancer cells, be harmless to normal tissue, and which could be systemically administered, thereby reaching tumor cells in all parts of the body. Theoretically such an agent should be found in the field of non-hormonal chemotherapy. The hope of finding such an agent has led to extensive investigation by many investigators of the possibility of various drugs in the treatment of cancer.

Judgment of Values

As the mass of reports on investigation and use of these drugs increases—there are more than 300 reports of articles each month in *Cancer Chemotherapy Abstracts*—it becomes more difficult and important that judgment be made of the current value of these agents. While the field of chemotherapy holds great promise of future development of cancericidal drugs, the physician is faced with the necessity of determining the usefulness of available drugs in the treatment of the patient today. Such an evaluation is of particular importance to the private practitioner who wishes to offer his cancer patients every benefit of modern therapy, and who is pressed by enthusiastic reports of results in both lay and professional publications, and who is urged by the quasi-informed family to “do all that can be done.” Encouraging reports of the use of non-hormonal agents can be found throughout the literature, and a less than critical appraisal may tempt the physician, unfamiliar with their use, to the injudicious utilization of them.

Field Is Broad

The field of chemotherapy is extremely broad, and a discussion of agents and methods of administration

are not within the scope of this brief presentation. Drugs and techniques are adequately described in many articles by competent authorities in the readily available current literature. While many articles present successful experiences with drugs, there would seem to be a need for emphasis of the failures and complications. Before the physician with limited experience with these drugs commits himself to their use, some cautions should be offered. These comments are not intended to indicate when chemotherapy should be used, but rather to present reservations which should govern their use.

At the present time, none of the currently used drugs have been proven to be curative; begging the question of choriocarcinoma and Methotrexate. When these drugs are used for palliation, the implication is that the patient should be symptomatic, or should be expected, in a reasonably short period of time, to become symptomatic from the disease.

Toxic Drugs

All of the effective drugs are extremely toxic. Furthermore, most require that toxic amounts be given to be effective. Even with the development of better techniques, such as slow and continuous infusions, better dosage schedules, and the use of antagonistic drugs systemically, reducing the toxic effect does not necessarily allow dramatic improvement in the efficacy of the drug. Our experience with multiple-agent therapy has demonstrated no significant change in the effect of the toxic and therapeutic relationship. Severe complications involving the reticuloendothelial system and the gastrointestinal system are common. Even when the drug is not lethal, the morbidity caused by it may be greater than that from the tumor.

The use of regional therapy by isolated perfusion, intraarterial infusion, etc., reduces the systemic toxicity by concentrating the drug in a desired area and reducing or eliminating its effect on the total body. Although certain tumors in certain regions, e.g. extremities, head and neck, allow particular application of regional therapy, this technique has a limitation common to surgical procedures; it has no effect on the distantly disseminated disease, the situation in which chemotherapy theoretically should have its greatest potential. Regional therapy requires a great deal of skill and familiarity with the drug and the techniques of administration, as well as special equipment. There are increased chances of surgical complications, particularly vascular complications.

Little Knowledge

Little is known of the long term results with cytotoxic drugs. There is a great deal that is not known about the "host resistance," but the possible effect on this so-called "host resistance" has concerned many persons. Recent work in host susceptibility has demonstrated a definite increased receptivity to the transplantation of "foreign" cells by the use of certain chemical agents. Some of the drugs, e.g. 6 Mercaptopurine, which were originally developed as anti-can-

cer drugs are now being used in tissue transplantation to increase host receptivity. The implication of possible increased host receptivity to cancer cells must be considered. This effect might materially alter the number of patients who "resist" their cancer for many years.

Interpretation Difficult

Interpretation of results from studies of cancer therapy in particular is extremely difficult because of the great variability in individual cases. Good control studies are difficult to obtain. Knowledge gained from the uses of these drugs at the present time, except in an extensive, well-designed, and controlled investigational program, is of questionable value.

The hope and effort for better cancer treatment is the wish of everyone. There is a great deal in chemotherapy investigation that is encouraging and promising. There are indications of "small advances" and means of relieving pain with some of the chemical agents. It would seem at the present time, until better agents are developed, that the use of cytotoxic drugs in private practice should be done with the greatest discrimination and due concern for the over-all effect on the patient in terms of risk, comfort, convenience, expense and long term survival.

Approved by Professional Education Committee, Georgia Division, ACS.

NEW DIRECTOR OF AMA'S SCIENTIFIC DIVISION ANNOUNCED

Hugh H. Hussey, M.D., dean of Georgetown University School of Medicine, Washington, D. C., and chairman of the American Medical Association's Board of Trustees, has been appointed director of the AMA's Division of Scientific Activities.

Dr. Hussey's appointment was announced recently by F. J. L. Blasingame, M.D., executive vice president of the AMA.

D.C. Native

Dr. Hussey, a native of Washington, D. C., and a graduate of the medical school of which he is dean, will resign from the Board of Trustees later this year and assume his new duties in 1963 at such time as he can be relieved of his responsibilities as dean, Dr. Blasingame said.

"The American Medical Association is extremely fortunate in being able to secure the services of Dr. Hussey to direct this important division whose activities in the area of medical science and education are of tremendous importance to the medical profession and the public," Dr. Blasingame said. "Dr. Hussey is widely known in the fields of medical education and internal medicine, and his exceptional administrative abilities

coupled with his extensive knowledge of all phases of AMA activities and programs will be invaluable assets to this association."

Seven Departments

As director of the AMA Division of Scientific Activities, Dr. Hussey will administer the programs of seven departments with more than 130 employees and an annual budget in excess of \$2,000,000. These departments include Foods and Nutrition, Drugs, Medical Physics and Rehabilitation, Medical Education and Hospitals, Nursing, Scientific Assembly and Advertising Evaluation.

ERRATUM

In the November 1962 issue of the JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, the name of James M. Wells, M.D., Macon, was omitted as one of the authors of the Scientific Article, "First Lumbar Root Syndrome." JMAAG wishes to correct this error and regrets the omission.



PULMONARY EMBOLISM

A. Calhoun Witham, M.D., *Augusta*

IT IS IMPOSSIBLE to discuss pulmonary embolism without reference to its source. Although approximately 90 per cent arise in the leg veins, the small pelvic veins, particularly in urological and obstetrical patients, may also seed the lungs. A reasonably common source in cardiacs is the right auricle or ventricle. An occasional obscure origin is the infected patent ductus arteriosus without the characteristic murmur. Air embolism is now uncommon but there are three other types of embolism which should be mentioned. Barium crystals have occasionally been found in the pulmonary arterioles of patients who died unexpectedly during barium enema. Embolism of amniotic materials is sometimes a cause of unexplained cardiovascular collapse after parturition. Fat embolism following bone trauma is well known and a fascinating new legal problem has appeared since the institution of closed chest cardiac massage. Necropsy almost always shows fat particles in the pulmonary arterial system, sometimes of impressive size. In cases of trauma there may be question as to whether these were the cause of arrest or resulted from cardiac massage *after* death.

Evidence Indicates

Although thrombophlebitis apparently may arise *de novo*, experimental evidence indicates that damaged endothelium is probably responsible and the mechanism is basically electrostatic. The negatively charged platelets are attracted to the area of damage which becomes relatively positive in polarity. Fibrin is trapped and the thrombus is underway. Stasis, trauma, and chemical irritants are well-known predisposing factors.

The physiology of pulmonary embolism is not entirely clear. In dogs, for example, sudden occlusion of a lobar artery by balloon catheter causes no measurable change in hemodynamics. Embolization of the same vascular tree by lycopodium spores

causes acute pulmonary hypertension, tachycardia, systemic hypotension and other signs associated with clinical embolism. Virchow observed that a single embolus did not cause death unless it was at least 30 cm. long. Numerous smaller ones, however, can prove fatal by effectively occluding the pulmonary arterial system. Ligation of one half the pulmonary tree, as in pneumonectomy, does not increase the resting pulmonary artery pressure, but not infrequently one or two moderate sized pulmonary emboli may cause acute *cor pulmonare* or sudden death. A pulmono-pulmonary reflex has been demonstrated wherein sudden occlusion of a part of the vascular bed causes generalized reflex arteriolar constriction and pulmonary hypertension. Although clinical experience supports this hypothesis, the reflex has been denied by others. The pathogenesis of acute pulmonary edema due to embolism is also hazy; reflex pulmonary venous constriction has been postulated but not clearly demonstrated. The factors governing whether the embolus results in infarction are not fully understood. Size of embolus is important but infarction is more likely to occur in congested or otherwise sick lungs. Repeated small emboli may result in *cor pulmonare* with strikingly avascular lung fields on X-ray. Multiple explanations for cyanosis exist with pulmonary arterio-venous shunting, pulmonary edema, and opening of a patent foramen ovale due to high right atrial pressure the most common. A peripheral mechanism exists when shock is present (slow blood flow). Pulmonary infarction statistically occurs more often peripherally and in the right lower lobe. Ventricular ischemia is often suggested by substernal pain and electrocardiographic findings and sudden death is probably often due to anoxic arrhythmias.

Hypothetical Case

A hypothetical patient may be described. He has sudden pleuritic pain, coughs fresh blood, his tem-

perature spikes and his respiratory and pulse rate rise abruptly. An inflamed tender cord is found in his calf, an accentuated "a" or "v" wave appears in the jugular vein and pleural friction rub, systolic ejection click, accentuated pulmonary valve closure and the murmurs of tricuspid or pulmonary regurgitation are heard. Electrocardiogram shows evidence of right ventricular conduction delay, strain and rotational changes and at 48 hours a peripheral wedge shaped density appears on X-ray. This patient is rare. More often signs are indeed subtle — unexplained rise in temperature, pulse, and respiration in postoperative patients, progressive failure in a previously stable cardiac, unexplained right heart failure in a patient with extraordinarily avascular lung fields, pleuritic pain in a migratory Yankee driving long hours toward Florida, unexplained vascular collapse in a postpartum or postoperative patient, acute pulmonary edema following prostatectomy, "pneumonitis" in the elderly. These situations suggest thromboembolism and call for repeated careful physical examinations, X-rays, serial electrocardiograms, bilirubin and enzyme studies. Common signs of active thrombophlebitis, unfortunately, are absent or equivocal in 50 per cent; but unilateral edema, fullness of the anterior tibial ("sentinal") vein and pain in the calf stimulated by a constricting blood pressure cuff must be actively sought. Even in prospective studies by alerted physicians, the antemortem diagnosis rate is only 50 per cent and is probably nearer ten per cent under less favorable circumstances. The diagnosis is dependent upon constant awareness of the clinical substrates upon which this condition flourishes.

Details of treatment differ but heparin is the cornerstone of current therapy. It is satisfactorily administered only by the intermittent intravenous route at least every eight hours. One scheme is to secure a control Lee-White clotting time and adjust subsequent dosage so that a just discernible prolongation (about five minutes) is retained before the next dose. Most patients will require 200 to 400 mg. per day. The anti-inflammatory effect is often prompt and striking. Deep breathing exercises and elevation and elastic binding of the affected leg are adjuncts. After inflammation has subsided, a dicumarol-like drug is substituted. It is important to obtain blood for prothrombin times when the influence of heparin is absent for it will affect this measurement. Ambulation is begun gradually during the second week and prothrombin time is maintained at two to two and a half times control for an additional three to five weeks. Predisposing diseases such as varicositis, blood dyscrasias, and occult malignancies are carefully excluded. Repeat embolization under adequate treatment calls for consideration of surgical prophylaxis. Nothing less than inferior venal caval ligation or partial occlusion by clipping seems effective. The latter procedure avoids the morbidity of ligation unless a large embolus lodges in the surgically created bottleneck. The morbidity is then the same as for ligation but would seem a reasonable exchange for probable fatal embolus. Long term anticoagulation should be continued even after constriction in the hopes of avoiding the above effect. Currently available thrombolytic agents are expensive and far from satisfactory but undoubtedly will be used more extensively in the future.

Prepared at the Request of the Committee on Professional Education of the Georgia Heart Association.

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SHELTERED RETIREMENT PLANS

John L. Moore, Jr., *Atlanta*

ON OCTOBER 10, 1962, the President approved Public Law 87-792, more commonly known as HR-10 or the Jenkins-Keough Bill. This law will allow groups of professional people to adopt profit sharing or pension plans even though they are not incorporated or practicing in the form of a professional association.

There are limitations on the amounts which can be contributed to the plans and rather more severe tax consequences than those available to employees of corporations.

Effective Date

Plans under the new Act may be put into effect for taxable years beginning after December 31, 1962. Thus a partnership of professional men with a tax fiscal year ending on November 30 of each year will be able to adopt a plan effective December 1, 1963. However, most professional offices report on the calendar year and therefore will be able to adopt plans effective January 1, 1962.

The maximum contribution in any year to a plan will be \$2,500 for any one person. "Self-employed persons" who are covered (that is, the sole practitioner or a partner) will be able to deduct from their taxable income only one-half of the contribution made in the taxable year. Regular employees of the sole practitioner or his group will be treated for tax purposes very much like the employee of a corporation, having no taxable income by reason of the contribution by the employer to the qualified trust in the particular year.

The income earned by the trust is tax free both to the sole practitioner or the partner and employee.

Distributions

Distributions from the trust must be complete by the time the particular person attains 70½ years and may be taken either in a lump sum or in the form of an annuity for the benefit of the person or his spouse or for the remaining lives of both. The retiring employee of a corporation which has a

qualified profit sharing or pension plan receives capital gains treatment and consequently a lower tax rate on taking down all of his benefits in one lump sum. However, the self-employed person, on a lump sum distribution, will be taxed at a special rate not so high as ordinary income tax rates but higher than capital gains rates.

Trustees

Plans for the self-employed must usually be trustees with a bank. Corporations may name individuals as trustees. However, plans for the self-employed, though naming the bank as trustee or custodian, may call for control of investments by the interested persons. A bank need not serve as trustee if the investments are limited to annuity, endowment, or life insurance contracts, and the life insurance company supplies whatever information the Treasury may require concerning transactions. The plan need not have a trustee at all if contributions are used to purchase annuities directly. A trustee is not needed if all contributions are invested solely and directly in certain United States bonds providing for the payment of no interest prior to maturity.

Special Restrictions

If a plan benefits a sole practitioner or a partner with more than a ten per cent interest, and most medical partnerships will be of this nature, certain additional restrictions apply. In such plans all full-time employees who have been employed by the partnership for at least three years must be covered and the amount of all contributions, both to the benefit of the doctor and his employees, must be based upon earnings. For example, the sole practitioner employing one secretary and one nurse, each of whom has been employed for more than three years, would have to provide for contributions for the benefit of the nurse and secretary. Such benefits would have to be nonforfeitable from the date of the contribution and, if the sole practitioner is to

make contributions based upon a certain percentage of his net earned income, contributions to be made for the benefit of the nurse and secretary will have to be based upon the same percentage of the amount they are paid as wages or salary.

Conclusion

The provisions of this new statute are quite complex. An article such as this cannot mention all of the details. There are important tax advantages now available to sole practitioners as well as to profes-

sional people who practice in a partnership without the information of a professional association. All medical doctors should be interested in checking this point with their attorneys and bankers.

The Insurance and Economics Board of MAG is actively working on possibilities of a master trust for MAG members. If this can be worked out, it would provide important economics and other advantages. Consequently, it is recommended that MAG members delay adoption of individual plans until the Insurance and Economics Board reports.

Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

SCIENTISTS REPORT ON EFFECTIVENESS OF REVOLUTIONARY ANTIMALARIAL DRUG

First reports on a new and promising approach to the eradication of malaria—the world's most important tropical disease which claims an estimated 1½ million lives annually—were delivered in Atlanta, November 1, 1962, at the annual meeting of the American Society of Tropical Medicine and Hygiene.

New Approach

The new approach involves development by Parke, Davis & Company scientists of a long-acting, injectable antimalarial drug. Following injection, the drug is absorbed slowly into the blood stream. The amount of the drug released is enough to maintain a high degree of immunity to the disease for more than six months.

At present, the common approach to the treatment of malaria is with oral medication. To assure maximum effectiveness, such medication must be taken continuously at intervals of approximately two weeks. This requirement for frequent administration has made it difficult to eradicate malaria in many parts of the world where the disease is a serious problem. The new reports suggest that the long-acting drug may enable the control or even the eradication of malaria where present methods have been tried and failed.

Reports on the experimental drug, known as CI-501, were delivered at the society's annual meeting by Dr. Paul E. Thompson, laboratory director in parasitology at Parke-Davis, and Dr. L. H. Schmidt, director of the Christ Hospital Institute of Medical Research, Cincinnati, Ohio.

Dr. Thompson first established long-term effectiveness of CI-501 in mice and monkeys infected by transfusions of malaria infected blood. Dr. Schmidt and his colleagues, Dr. Richard N. Rossan and Mrs. Kathleen F. Fisher, showed the drug was equally effective in monkeys infected with malaria parasites derived from mosquitoes. The work of the Cincinnati institute was important because malaria transmitted by infected mosquitoes is the natural infection and responds somewhat differently to drugs than malaria transmitted by blood transfusions.

Parke-Davis supplied CI-501 to Dr. G. Robert Coatney, National Institutes of Health, for trial as a long-acting antimalarial in man. Dr. Coatney and his associates reported their clinical results at the same meeting. The drug is not yet available for general use.

In his paper, Dr. Thompson reported that a single dose of CI-501 protected monkeys for an average of 34 weeks, although some were protected for more than 50 weeks. None of the doses caused local irritation or were systemically toxic. He also reported that malaria-infected animals treated with CI-501 showed a "strong therapeutic response within 48 to 72 hours."

Co-authors on the Parke-Davis reports were Dr. Edward F. Elslager, laboratory director in organic chemistry, and Donald F. Worth, who together first conceived and prepared CI-501, and Bronislawa Olszewski who participated in the biological studies.

In Dr. Schmidt's study, monkeys were injected with the drug. One week later, and then at monthly intervals for a seven-month period, attempts were made to infect the animals. None of the treated animals came down with malaria, although untreated animals "developed infections within eight and nine days."

Research Years

Reports delivered on the development and testing of CI-501 in animals climaxed five years of research by scientists at Parke-Davis. The pharmaceutical firm embarked in 1957 on a program aimed at developing an antimalarial drug that could have a combination of immediate effect, prolonged action, and little or no toxicity.

The new drug was selected from among more than 500 compounds synthesized for long-acting antimalarial studies by a team of Parke-Davis chemists including Dr. Elslager, Mr. Worth, Dr. Leslie M. Werbel and Dr. David B. Caps. Biologists who contributed to the development included Miss Anita Bayles and Mr. J. E. Meisenhelder.

Chemically, CI-501 is the pamoic acid salt of 4, 6-diamino-1-(*p*-chlorophenyl) -1, 2-dihydro-2, 2-dimethyl-*s*-triazine.



Beckel, Frank, M.D., Medical College of Georgia, Augusta, Georgia, "A Method for Prolonged Intravenous Infusion of Rabbits," *Am. J. Clin. Path.* 38:135-139 (Aug.) 1962.

A method is described for the continuous intravenous infusion of rabbits over periods of ten days or longer. A marginal ear vein is used, and only one puncture is necessary. The usual rate of infusion is 15-20 ml. an hour. The equipment required is easily available and, with the exception of the automatic pipetting device used as a pump, inexpensive.

Stone, H. Harlan, M.D.; Kurtz B. Stowers, M.D.; and Stuart H. Shippey, M.D., Emory Hospital, Atlanta 22, Georgia, "Injuries to the Pancreas," *Arch. Surg.* 85:525-530 (Sept.) 1962.

During a 13 year period, 62 cases of pancreatic injury were treated surgically at Grady Memorial Hospital. Fifty-six of these were penetrating wounds, and six were secondary to blunt abdominal trauma. Significant complications were noted in 71 per cent, and death resulted in 21 per cent. The major problems encountered were hemorrhage, associated organ injuries, and pancreatic complications. The seriousness of pancreatic complications is stressed. Certain principles of care for the pancreatic wound have evolved: 1) hemostasis, 2) conservative debridement, and 3) control of pancreatic secretions. Sump drainage is a necessity for all cases of pancreatic trauma. In minor injuries it may constitute the sole therapy; in major trauma, it should be used as an adjuvant measure.

Riggsbee, John B., M.D., Georgia Institute of Technology, Atlanta, Georgia, "Accidents at College," *G.P.* 26:88-93 (Sept.) 1962.

One year's experience with trauma among students at Georgia Tech is reviewed and analyzed according to mode of occurrence, major types and anatomical location of the injuries. Although most injuries to college students are relatively minor, serious injuries can and do occur. 1,564 injuries are reported. Fifty-two per cent were received in athletics (intercollegiate sports not included); of these, 56 per cent were received while playing football or basketball. Approximately 80 per cent of the injuries involved the distal portion of the extremities but every portion of the anatomy was involved at some time. Less than five per cent needed hospitalization and less than seven per cent needed treatment by a specialist. Only four per cent were caused by auto accidents, but these caused 35 per cent of the loss of school time and 65 per cent of the costs of hospitalization. Emphasis is placed on the need for prevention through safety education, proper selection of students allowed to participate in sports, adequate physical condition-

ing, and competent supervision of contact sports. Early treatment is stressed in order to prevent complications and promote recovery without undue loss of time from classes.

Engler, Harold S., M.D., and Sweat, Russell, M.D., Medical College of Georgia, Augusta, Georgia, "Volumetric Arm Measurements: Technique and Results," *Am. Surgeon* 28:465-468 (July) 1962.

Edema of the arm in conjunction with advanced cases of carcinoma of the breast and following radical mastectomy has been of interest to surgeons for many years. The cause of arm edema following radical mastectomy has not been established. In studies concerned with this problem, measurements of the edematous arms should be as accurate as possible. This study is concerned with an accurate method of measuring the volume of arms using the principle of displacement of water. It describes the technique used and results obtained in measuring the right and left arms of a group of normal women comparing the size of the arms and establishing a range within which any difference in the size of the two arms could be considered normal. Statistically the area of method was found to be only ten cc. or less than one per cent. From the data obtained in this study it was predicted that in 95 per cent of normal women the difference in arm volumes will be no more than 150 cubic centimeters.

Wright, A. D., Jr., M.D., Emory University School of Medicine, 69 Butler Street, Atlanta 3, Georgia, "Fluorescence Microscopy in the Study of Skin Tumors," *South M. J.* 55:769-773 (Aug.) 1962.

Slide imprints from skin biopsy specimens were studied utilizing the acridine orange stain and Fluorescence Microscopy. This technique utilizes the special property of acridine orange to stain the nucleic acids within cells. The increased content of nucleic acids in malignant cells causes these cells to appear with bright fluorescence when studied under a microscope utilizing an ultraviolet light source.

Tissue imprints were made from 202 different skin biopsy specimens representing benign and malignant lesions.

There proved to be a rather high correlation between the result obtained with this method and the definitive diagnosis from routine hematoxylin and eosin sections as far as differentiating between benign and malignant lesions is concerned.

The advantages of this method lie in the rapidity with which a preliminary report can be given. The limitations place this technique in the category of an adjunctive procedure only.

A critical evaluation of this method as it applies to skin tumors must await further experience and a larger series of cases.

Maholick, Leonard T., M.D., and David S. Shapiro, Ph.D., The Bradley Center, Inc., Columbus, Georgia, "Changing Concepts of Psychiatric Evaluation," *Am. J. Psychia.* 119:233-236 (Sept.) 1962.

The Bradley Center, a private, non-profit, outpatient psychiatric center, became concerned with the efficiency, effectiveness, and appropriateness of traditional intake and diagnostic procedures for applicants for psychiatric services. A detailed study of 30 consecutive adult applicants suggested that such conventional methods (a social work interview, psychological testing, staff conferences, and a final interview with the psychiatrist) do not contribute significant information commensurate with the time and effort invested.

A thorough revision was achieved by substituting a pre-interview battery of self-administered tests and questionnaires for the social work interview and routine psychological examination. The Medical-Director (psychiatrist) after studying a Biographical Questionnaire, the Mooney Problem Check List, the Cornell Index, and the MMPI (with a short psychological interpretation) was able to see the patient initially and in an hour's session arrive at an initial diagnosis, discuss treatment plans, and prescribe needed medication. Benefits achieved included a reduction in cost for the patient and the Center; marked reduction in unproductive diagnostic interviews and conferences; increased number of treatment hours to accommodate more psychotherapy; and more rapid movement of patients into treatment. Psychologists and social workers were freed from unproductive, routine duties and were able to provide more treatment services under psychiatric supervision and additional time was made available for a community-oriented mental health research program.

Wenger, Nanette Kass, M.D., and Galambos, John T., M.D., Emory University School of Medicine, Atlanta 22, Georgia, "Spontaneous Decompression of Portal Hypertension," *South. M.J.* 55:907-909 (Sept.) 1962.

A single large portosystemic anastomosis was demonstrated by splenoportography in a case of postnecrotic cirrhosis. There was no clinical evidence for portal hypertension, and at operation for hypersplenism, the usual collateral circulation associated with portal hypertension was absent.

Spontaneous portosystemic anastomoses may effectively prevent the development of portal hypertension. There is danger of transection of a patent umbilical vein at operation in a patient with unsuspected cirrhosis. Roentgenographic demonstration and recognition of these spontaneous shunts can prevent their inadvertent destruction during abdominal surgery.



THE ASSOCIATION

DEATHS

DEWITT PRITCHETT, 75, of Barnesville, died at Griffin-Spalding County Hospital October 5, 1962.

Dr. Pritchett, a widely known eye, ear, nose, and throat specialist who maintained offices in Barnesville and Thomaston, was graduated from Emory University, attended Tulane University, and was a student at Cook County Hospital in Chicago, Illinois. He was a member of the Pleasant Hill Methodist Church in Lamar County.

Dr. Pritchett is survived by his wife, Mary Bass Pritchett, Griffin; one daughter, Mrs. James C. Bridges of Thomaston; a son, Harris Pritchett, Industry, Penn.; three sisters, Mrs. Roscoe Treadwell of Cataula, Ga., Mrs. Joe Adams and Mrs. Eula Mayo, Barnesville; two brothers, Allen Pritchett, Perry, Ga.; and Dr. W. L. Pritchett, Atlanta; five grandchildren; and four great-grandchildren.

EMMETT WARD, 75, a general practitioner in Atlanta for 46 years, died October 4, 1962, in a private hospital.

Dr. Ward, a graduate of Emory University School of Medicine, was a member of the Cedar Grove Methodist Church, the E.A. Minor Lodge No. 603 F&AM, the Mt. Zion Chapter R.A.M., and the Yaarab Temple.

Dr. Ward is survived by his wife, Minny Nicholson Ward; and a sister, Mrs. Eliza McDonald, Middleburg, Florida.

ALTON WALKER DAVIS, 72, Warrenton physician died October 7, 1962, in an Atlanta hospital after a brief illness.

Survivors include Dr. Davis' wife, Ethma Darden Davis; one daughter, Mrs. Charles R. White, Warrenton; a son, Alton W. Davis, Jr., Warrenton; a sister, Mrs. Arthur Yarborough, Mitchell, Ga.; and four grandchildren.

KIMSEY E. FOSTER, 70, retired College Park physician died October 9, 1962, in a local hospital.

Dr. Foster was a member of the Fulton County Medical Society, the College Park Masonic Lodge No. 454, the Lyle and Brewster Post, American Legion, the "30" Club of College Park, and the College Park Methodist Church.

He is survived by his wife, Nell Croley Foster; two daughters, Mrs. R. T. Lloyd and Mrs. M. F. Norris, College Park; and one brother, Dr. John K. Foster, College Park.

SOCIETIES

COWETA COUNTY MEDICAL SOCIETY met in Newnan, Georgia, October 9, 1962. Dr. Earnest Barron presented a paper on, "Post-myocardial Dressler Syndrome," after which a short discussion followed.

GEORGIA MEDICAL SOCIETY met November 12, 1962, at Savannah. Dr. Vernelle Fox, Director of the Georgian Clinic for Alcoholism, Atlanta, was the speaker for the program.

GLYNN COUNTY MEDICAL SOCIETY met September 23, 1962, at Brunswick, Georgia. Professor of Neurosurgery at the University of Georgia, Dr. George Smith, Augusta, presented a discussion on Carotid Strokes.

SOUTHWEST GEORGIA MEDICAL SOCIETY and its Woman's Auxiliary met in October in Blakely with Dr. and Mrs. Warren Baxley as hosts. After the business meeting, a scientific program was given by Dr. A. S. Trulock, Jr., of Albany. Dr. Trulock spoke on the treatment of varicose veins.

TROUP COUNTY MEDICAL SOCIETY met at LaGrange September 4, 1962. A social hour and dinner was enjoyed by the members of the society and their guests, a number of members of the local bar association. A panel discussion was held on the subject, "Relationships Between Doctors and Attorneys Locally," presided over by Judge J. C. Jackson. Members of the panel were Dr. William B. Fackler, Jr., and Dr. J. S. Holder, and attorneys Mr. Horace, Mr. Richter, and Mr. Ketsky.

PERSONALS

First District

KATRINE HAWKINS of Sylvania attended the annual session of the Georgia Academy of General Practitioners held in Atlanta October 25-27, 1962.

President of the Medical Association of Georgia, THOMAS GOODWIN, Augusta, was one of the members of a three man panel discussing "Medical Care for the Aged," at the JEA public forum held October 16, 1962, in Savannah.

Addressing the Georgia Medical Society at their meeting held October 2, 1962, in Savannah, was HARRY B. O'REAR, President of the Medical College of Georgia at Augusta.

Former Columbus psychiatrist, FREERK W. WOUTERS, opened an office in Savannah October 12, 1962.

Second District

HOMER L. LASSITER and ROBERT E. JENNINGS, Arlington, have proved successful graduates of Georgia's medical scholarship program. They agreed to locate in Arlington where the Arlington City Hospital had been closed because of lack of physicians. Dr. Lassiter and Dr. Jennings, the only two physicians in Arlington, now serve patients from Arlington, Calhoun, Early, Baker, and Randolph counties.

THE ASSOCIATION / Continued

Third District

RUSSELL THOMAS, SR., Americus physician, is now in the St. Francis Hospital at Columbus. Dr. Thomas was formerly a patient at the Americus and Sumter County Hospital.

Fourth District

Hogansville physician, E. T. ARNOLD, has accepted an invitation to membership in the New York Academy of Sciences, comprised of scientists representing every area of scientific endeavor.

Fifth District

Named recently as a member of the Executive Committee of the Seaboard Airline Railway Surgeon's Association from the State of Georgia, was DAVID HENRY POER, Atlanta.

JOHN T. LESLIE, Decatur, assumed his duties as Director of Crippled Children's Service, State Health Department, October 1, 1962.

Secretary of the Atlanta Ophthalmological Society, HARRY ARNOLD, Atlanta, spoke to opticians at their annual meeting October 27, 1962, at the Atlanta Americana Motor Hotel. "What the Ophthalmologist Expects of the Dispensing Opticians," was the subject of Dr. Arnold's talk.

JOHN R. LEWIS of Louisville, Georgia, and Atlanta, was the subject of a feature article which appeared in an October issue of *The Georgia Magazine*. The unusual combination of profession-psychiatry, and hobby-poetry, sparked the idea for the feature. *To Dock at Stars*, a book of lyric poetry, and *The Surgery of Scars*, are two of the books which Dr. Lewis has had accepted for publication.

"Auto-Radiographic Studies of the Mechanism of Disposition of Radioactive Cholesterol in the Rabbit Aorta," was the subject of a paper presented at the American Heart Convention in Cleveland, Ohio, November 26, 1962, by ROBERT SCHLANT, Atlanta. Dr. Schlant and JOHN GALAMBOS, Atlanta, are authors of the paper.

FREDERICK A. CARPENTER, Atlanta, presented a paper entitled, "Subarachnoid Alcohol Block," to the University of Colorado Medical Center, and another paper on "Evaluation of Preanesthetic Medication," to the Colorado Society of Anesthesiologists at the Psychophysiological Research Society Meeting in Denver, October 11-15, 1962.

Attending the American Society for Microbiology meeting in Chicago, October 30-November 2, 1962, was THOMAS F. SELLERS, JR., Atlanta.

JOHN H. VENABLE, Atlanta, Director of the State Department of Health, has recently been appointed a member of the National Commission on Community Health Services.

OSLER A. ABBOTT, Chief of Thoracic Surgery at the Emory University Clinic, has recently been chosen as a member of a medical team being sent by the U. S. State Department to teach International Postgraduate Circuit courses abroad.

Professor of Radiology at Emory University, TED F. LEIGH, Atlanta, was guest lecturer in Radiology at the Oklahoma City Clinical Society annual meeting in Oklahoma City, October 29-31, 1962.

Sixth District

Dublin physician and surgeon, JOHN A. BELL, JR., was installed as President of the Seaboard Airline Railway Surgeon's Association in October at Washington, D.C.

SHANNON MAYS, Macon psychiatrist, was elected a vice president at the recent meeting of the Southern Psychiatrists Association held in Galveston, Texas.

WILLIAM S. HELTON, Sandersville, is now located in a new office at 520 and 522 Washington Avenue, Sandersville.

Seventh District

DAVIS M. NOWELL, Dalton, has been elected President of the medical staff of Hamilton Memorial Hospital at Dalton for the fiscal year of 1962-63. Dr. Howell assumed his duties October 1, 1962.

Eighth District

No news submitted.

Ninth District

No news submitted.

Tenth District

MARION HUBERT, Athens, University of Georgia's "football physician," is recovering from a serious operation in Athens General Hospital.

The award of Physician of the Year in Georgia has recently gone to KING MILLIGAN of Augusta.

Celebrating the Silver Anniversary of the Class of 1937 of the Medical College of Georgia in Augusta recently were two members of the class, SAM E. PATTON, of Macon, and L. H. GRIFFIN of Claxton.

Co-author of the book, *Three Faces of Eve*, HERVEY M. CLECKLEY, Augusta psychiatrist, has recently contributed a section to a new book entitled, *Psychiatry and Responsibility*.

EXECUTIVE COMMITTEE OF COUNCIL MEETING MINUTES

THE MEETING OF THE Executive Committee of Council was called to order at 10:05 A.M., November 4, 1962, at the MAG Headquarters Building, Atlanta, Georgia, by the President Thomas W. Goodwin.

Members of the Executive Committee present were Thomas W. Goodwin, Augusta; George H. Alexander, Forsyth; John T. Mauldin, Atlanta; George R. Dillinger, Thomasville; J. G. McDaniel, Atlanta; Fred H. Simonton, Chickamauga; Lee H. Battle, Rome; and John S. Atwater, Atlanta. Also attending the meeting were J. Frank Walker, Atlanta; James A. Kaufmann, Atlanta; Mr. James L. Bentley, Comptroller General Elect, Atlanta; and Mr. John Moore, MAG Attorney. MAG Staff members present were Mr. Milton D. Krueger, Mr. James M. Moffett, Mr. James Baker, and Mrs. Catherine Wooten.

Reading of Minutes

Mr. Krueger reviewed the minutes of the Executive Committee meeting of October 11, 1962, and it was suggested by Dr. Simonton that the wording under the heading "Proposed AMA Resolution" be changed to read "After discussion, on motion duly made and seconded, it was voted that MAG not sponsor the DeTar Resolution." With this correction made in the minutes, upon motion duly made and seconded, the minutes were approved as read.

Medicare

Mr. Baker, Medicare Administrator, stated that in setting up the new Medicare boards, the State Review Board became a Review Board and the State Medicare Board became the policy suggesting group, therefore, it was necessary to take action on the following:

(a) Review Board Chairman Appointment—After discussion, it was voted that the Chairman should be the Chairman of both Boards.

(b) Appointment of State Review Board members—On motion (Mauldin-Simonton) it was voted to appoint George T. Henry, Barnesville, as a representative of a small hospital to serve on the State Review Board, with an alternate, Alex P. Jones, Griffin; and to reappoint the three other members already serving on the board, Vernon Skiles, Atlanta; August B. Turner, Atlanta; and L. Guy Chelton, Atlanta. On further motion it was voted that the Medicare Rules and Regulations should be changed to read "the State Review Board should be composed of three or more members."

(c) On motion duly made and seconded it was voted to approve the Rules and Regulations with amendments as stated above.

AMA S.E. States Hospitality Room Expenses

Secretary Mauldin asked that funds be taken from Office Travel and appropriated for the AMA S.E. States Hospitality Room for the AMA Los Angeles meeting, November 24-28, 1962. On motion duly made and seconded it was voted to approve that the Secretary's suite be charged to Office Travel in the future.

Headquarters Office Report

Mr. Krueger discussed (1) The County Society Officers Conference program scheduled for March 2-3, 1963, at the Dinkler Hotel; (2) Projects such as County Society Speakers Bureau; Physicians not in private affiliation with Organized Medicine; Newspaper advertisements on "Doctor Image"; Woman's Auxiliary Liaison with Lay Women's Groups; Assistance to Allied Organizations on Non-medical Problems; Liaison with certain other organizations; and ERF Medical Scholarship Fund Raising Program. It was suggested that another meeting should be held in January 1963 to discuss the Projects and Aims, similar to the one held at Dr. Simonton's farm last year. In the meantime Mr. Krueger is to formulate an outline of these projects and mail them to the Executive Committee. After discussion about the newspaper advertisements it was recommended that they be published in their local papers, and it was requested that the county medical societies notify MAG of their action. On motion (Alexander-Dillinger) it was voted that the Executive Committee recommends the publication of these advertisements to the county medical societies.

Family Responsibility Bill

President Goodwin brought the Executive Committee up to date regarding the Family Responsibility Proposal. Dr. Goodwin read a letter from Drs. Byne and Venable which was in reply to his letter to them dated October 15, 1962. In the October 19, 1962, letter from Drs. Byne and Venable it was stated that the Family Responsibility Proposal, as worded, did not constitute the practice of medicine by the State of Georgia. After discussion Dr. Goodwin recommended that in view of this statement it should be clarified by the MAG Attorney. Mr. Moore, present at this meeting, then stated that it was his suggestion that he and Mr. Therrell, the State Board of Health Attorney, meet to draw up a proposal which would be approved by MAG. On motion (Alexander-Simonton) it was voted that the MAG Attorney be requested to meet with the State Board of Health Attorney to attempt to work out problems involved in the presently proposed Family Responsibility Bill, and to report back to the Executive Committee on this action.

Other Business

Georgia Urological Association Guest Speaker Expense: It was recommended that Dr. Mauldin and Dr. McDaniel talk with

the President of this specialty society regarding the payment of these expenses from the Savannah Annual Session in 1962, in the amount of \$197.10.

(c) Shrine Hospital for Burned Children in Upson County; Dr. Simonton stated he had talked with Dr. Patton about the hospital being constructed in a more suitable medical center. However, this information had been written to Dr. Patton previously.

New Business

(a) House of Delegates Actions: Dr. Walker asked for Executive Committee decision on the following:

(1) Health Insurance Council Liaison Committee Meeting—It was recommended that the committee meet with the Health Insurance Council and be encouraged to arrange a meeting.

(2) One Year Internship Prerequisite for Georgia Licensure—To be discussed by Joint MAG-State Board at a meeting to be set up on a Wednesday in November with Mr. Clifton and Dr. Savage of the State Board; and Drs. Goodwin and Mauldin and Mr. Krueger, of MAG.

(3) State Disciplinary Board—A liaison committee is to be appointed, as MAG representatives met with the State Board of Medical Examiners recently and established the purpose of the MAG House of Delegates request for a State Disciplinary Board.

(4) Disaster Medical Care Subcommittee—A statewide meeting of medical leaders from every local society had been directed by the House of Delegates. It was recommended that Executive Committee contact the Chairman of this Subcommittee regarding this action.

(5) Delegates and Alternate Delegates Expenses at AMA Meetings—This was referred to the Finance Committee for consideration at the November meeting.

(6) Confidential Nature of Certain Health Records—The Legislative Board is to have the author of the Resolution (Lester Rumble, Atlanta) to explain what he desires.

(7) Revise and Publicize a Minimum Medical Association of Georgia Standards for Blood Banking—The Executive Committee is to write Dr. Jack Norris, Chairman of the Blood Banks Subcommittee.

(8) Revision of Workmen's Compensation Fee Schedule Upward—The Executive Committee is to write T. A. Peterson, Savannah, Chairman of the Board of Occupational Health.

(9) Implement Traffic Safety—The Executive Committee is to write Joseph B. Mercer, Brunswick, Chairman of the Public Service Subcommittee.

(10) Telephone Credit Card for President-Elect—On motion duly made and seconded it was voted to approve the issuance of a telephone credit card for George R. Dillinger, President-Elect.

(11) Paramedical Education Program—Secretary Mauldin stated that Dr. R. C. Williams had called him regarding the establishment of a course at Georgia State College for students interested in paramedical education. On motion (Alexander-Atwater) it was voted that the MAG approves the program.

(12) H.R. 10—Self Employed Individuals Tax Retirement Act of 1962—Dr. Mauldin gave some background information about H.R. 10. After some discussion it was decided that it would not be advisable to do anything in this regard until the Internal Revenue information is published.

Insurance Commissioner Liaison on Health Insurance Matters

Mr. James L. Bentley, Comptroller General and Georgia Insurance Commissioner Elect, was present at this portion of the meeting, with Dr. James A. Kaufmann, Atlanta, to establish liaison with MAG and after introduction by President Goodwin, he asked for cooperation and promised support from the Insurance Commissioner in all problems of health insurance. Dr. Kaufmann assured the Executive Committee that Mr. Bentley will give the Medical Association his full support. Mr. Krueger then reviewed the discussion prior to Mr. Bentley's arrival regarding certain suggested goals as follows: (1) A liaison committee available to the Comptroller General's office; (2) The need for a public education program in the field of health insurance; (3) The need for cognizance of regulation on misrepresentations and abuses of health insurance by some few insurance companies, some few insurance agents, the policy holder, and the physician; and (4) Cooperation in the promulgation of standardized health insurance forms. Dr. Goodwin thanked Mr. Bentley and Dr. Kaufmann for attending this meeting and assured them of MAG's wholehearted cooperation.

THE ASSOCIATION / Continued

New Business (continued)

(13) Headquarters Staff Personnel—Secretary Mauldin discussed staff employment. On motion duly made and seconded it was voted to pursue the matter further and refer this matter to Council for consideration.

(14) Appointment of Rural Health Subcommittee Chairman—Mr. Krueger stated that Dr. Reid Gullatt, Cochran, had moved his practice to Florida, and a replacement would have to be appointed. On motion duly made and seconded Thomas N. Lumsden, Clarkesville, was appointed.

(15) Date and Site of December Executive Committee Meeting: This meeting will be held on December 8 in Albany. The time is to be decided by consultation with the President and Secretary.

There being no further business the meeting was adjourned at 3:45 P.M.

SPECIAL TELEPHONE CONFERENCE EXECUTIVE COMMITTEE MEETING

A SPECIAL TELEPHONE conference call meeting of the Executive Committee of Council was called at 3:30 P.M., November 8, 1962, by the President Thomas W. Goodwin, for the purpose of considering a plan for the Family Responsibility Bill as presented by the MAG Attorney, Mr. John Moore, after a conference with the State Department of Public Health Attorney,

Mr. James Therrell.

The roll call was taken and those present included Thomas W. Goodwin, Augusta; George R. Dillinger, Thomasville; Fred H. Simonton, Chickamauga; Lee H. Battle, Rome; George H. Alexander, Forsyth; J. G. McDaniel, Atlanta; John S. Atwater, Atlanta, and John T. Mauldin, Atlanta. Mr. Milton Krueger and Mrs. Catherine Wooten were present on the conference call as MAG staff representatives.

Discussion on the Family Responsibility Proposal

Mr. Moore stated that he had worked with Mr. Therrell on a proposal that would consist of the rendering of a single bill based on a per diem rate for professional services to simplify billing for the State Department of Health, and a contract agreement between the physicians themselves to insure that the fees collected for their services were donated for research purposes. There was general discussion on all phases of this proposal and it was accepted in principle, and the final agreement between the members of the Executive Committee was that, because the Legislative Study Committee was meeting tomorrow, November 9, 1962, Dr. McDaniel and Mr. Moore would appear before that group, make the MAG proposal known to them, and ask for an extension of one week for submission of the proposal. Mr. Moore was also instructed to send a copy of his proposal to the Executive Committee members for their perusal and it was decided that another telephone conference call would be scheduled for next week.

The conference telephone meeting was adjourned at 4:03 P.M.

W. B. SAUNDERS COMPANY ANNOUNCES \$15,000 WRITING FELLOWSHIP GRANT

To mark its 75th Anniversary in 1963, The W. B. Saunders Company, medical and scientific publishers, are making available \$15,000 for an unusual medical writing award. A distinguished committee will select the grantee.

The purpose of this grant is to provide financially for a year's leave of absence for a distinguished investigator who:

- (1) Has been doing fruitful and significantly important biomedical laboratory research over the past several years.
- (2) Would like to have time for thought and for preparation of his work in monographic form.

The recipient of the award will not have to agree to publish his monograph with the Saunders Company and will be free to write, instead of a book, a series of journal articles reviewing his research.

Areas of research in the medical sciences and clinical medicine which are acceptable for award consideration are extremely broad with a preference for those which could be translated into clinical usefulness within the foreseeable future. The investigator should be a resident of the Americas; but he may be doing or have done his laboratory work outside the Western Hemisphere.

Applications for the Saunders Writing Award may be submitted in an informal style to the Chairman of the Selection Committee. The investigator should indicate briefly the character of his research and where it has been pursued, along with a short resume of his scientific background and a bibliography of his important papers.

Various members of the committee who will review applications will be men most likely to be knowledgeable about both the applicant and the nature of his work.

The Selection Committee is as follows:

Chairman—Robert F. Loeb, M.D.

Committee Members:

Philip K. Bondy, M.D., Yale University School of Medicine.

Charles G. Child, III, M.D., The University of Michigan School of Medicine.

Robert E. Cooke, M.D., Johns Hopkins University School of Medicine.

George W. Corner, M.D., American Philosophical Society.

Louis K. Diamond, M.D., Harvard Medical School.

Dr. Rene J. Dubos, The Rockefeller Institute.

Don W. Fawcett, M.D., Harvard Medical School.

Joseph Garland, M.D., New England Journal of Medicine.

Harold S. Ginsberg, M.D., University of Pennsylvania School of Medicine.

Frank L. Horsfall, Jr., M.D., Sloan-Kettering Institute.

Seymour S. Kety, M.D., National Institute of Mental Health.

Mr. Henry Allen Moe, John Simon Guggenheim Memorial Foundation.

Carl V. Moore, M.D., Washington University School of Medicine.

Robert S. Morison, M.D., Rockefeller Foundation.

Dr. Theodore C. Ruch, University of Washington School of Medicine.

Dr. Richard H. Shryock, American Philosophical Society.

DeWitt Stetten, Jr., M.D., National Institutes of Health.

Dr. Claude A. Villee, Harvard Medical School.

Mr. John T. Wilson, The University of Chicago.

Applications should be submitted between January 1, 1963 and May 1, 1963, directly to Dr. Robert F. Loeb, care of W. B. Saunders Company, West Washington Square, Philadelphia 5, Pennsylvania. A decision on the award-winner will be reached by August 1, 1963, and the recipient notified. Formal presentation will be made at an award dinner in October, 1963.

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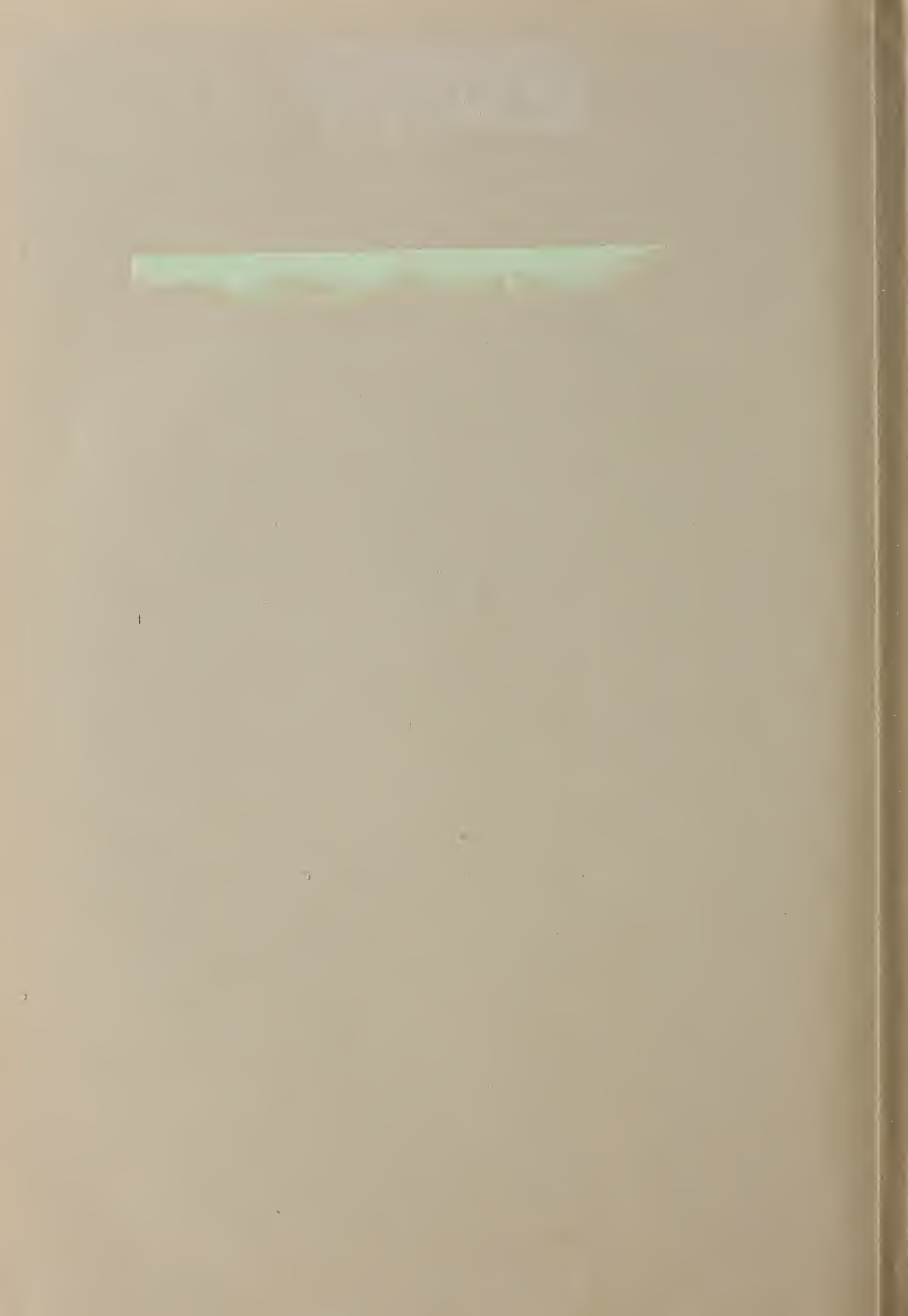
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